

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 4 2 5 4 2 5		
												REG. NO.		
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR		
			William L. Gatten						9 11 84			10:15AM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Male		Cauc.		8 19 18			66							
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH				
Wash D.C.		USA					Prince George			Suitland				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				
3414 Curtis Dr. Apt. 506				retired Clerk			Fed. Gov't.			Maryland Pr. George Suitland				
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		13e. STREET ADDRESS / ZIP CODE			
William J. Gatten		Lillian Morgan			yes WWII		577-14-6365		Thelma H. Gatten same as item 13		3414 Curtis Dr. apt. 506 20746			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Invention</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u>														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>5/3</u> , 19 <u>84</u> , to <u>9/11</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the deceased alive on <u>5/24</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.												22c. DATE SIGNED <u>9/12/84</u>		
22b. SIGN <u>David J. Haidak</u>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S ADDRESS (TYPE OR PRINT)			22e. ADDRESS											
David J. Haidak, M.D.			7801 Old Branch Ave. Clinton, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 9/14/84			23c. NAME OF CEMETERY OR CREMATORIAL Md. Veteran Cemetery			23d. LOCATION CITY OR TOWN Cheltenham COUNTY P.G. STATE Md.					
24. FUNERAL DIRECTOR NAME G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.						25a. DATE REC'D. BY REGISTRAR SEP 13 1984			25b. REGISTRAR'S SIGNATURE <u>Jisha Davidson-Randall</u>					

ANALYSIS OF THE POLARIZATIONS  
OF THE LIGHT FROM THE SUN  
AND THE PLANETS

BY  
JAMES CLARK MAXWELL  
F.R.S.  
PROFESSOR OF PHYSICS IN THE UNIVERSITY OF GLASGOW  
AND AUTHOR OF "THERMODYNAMICS", "ELECTRICITY AND MAGNETISM",  
"THEORY OF MAGNETIC POLARISATION", &C.

PRINTED BY JAMES HODGE, 1861.  
LONDON: LONGMAN, GREEN, AND CO., 1861.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "HOLDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR VITAL RECORDS FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.	25426				
1- STATE REGISTRAR																	
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED					
<i>John</i>			<i>Gerry</i>			<i>Geraghty</i>						Dec 15 1984					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR MONTHS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD					
m w				June 30 1932 59		YRS.						Sept 15 1984					
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Connecticut</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>									8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD.		
10. CITY OR TOWN OF DEATH <b>Laurel</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Laurel Bellwille 4</b>									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>photographer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>D.C. Govt</b>		
13a. STATE <b>Md</b>			13b. COUNTY <b>Hanover County</b>		13c. CITY OR TOWN <b>Laurel</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>3419 Urban</b>			207074				
14. FATHER'S NAME FIRST <b>John Geraghty</b>			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST <b>Linda</b>			MIDDLE			LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>			16b. SOCIAL SECURITY NO. <b>1951-55</b>			16c. ADDRESS			17. INFORMANT <b>Marion Geraghty same as above</b>			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18b. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis-</b>			DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.			(b) DUE TO, OR AS A CONSEQUENCE OF														
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <b>None</b>																	
19a. DATE OF OPERATION <b>None</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION									STATE		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>		
															and in my opinion		
															TITLE (SPECIFY) <b>John Rogers</b>		
ACTUAL SIGNATURE						M.D.			MEDICAL EXAMINER			DATE <b>Sept 18 1984</b>					
EXAMINER'S NAME (TYPE OR PRINT)																	
EXAMINER'S ADDRESS																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <b>Burial Sept 18, 1984</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Maryland Vet. Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Crownsville, Maryland</b>			COUNTY			STATE		
24. FUNERAL DIRECTOR NAME <b>Donaldson Funeral Home, Laurel, Maryland</b>			ADDRESS			25a. DATE REC'D. BY REGISTRAR <b>SEP 21 1984</b>			25b. REGISTRAR'S SIGNATURE <b>John Davidson - Pendell</b>								

A



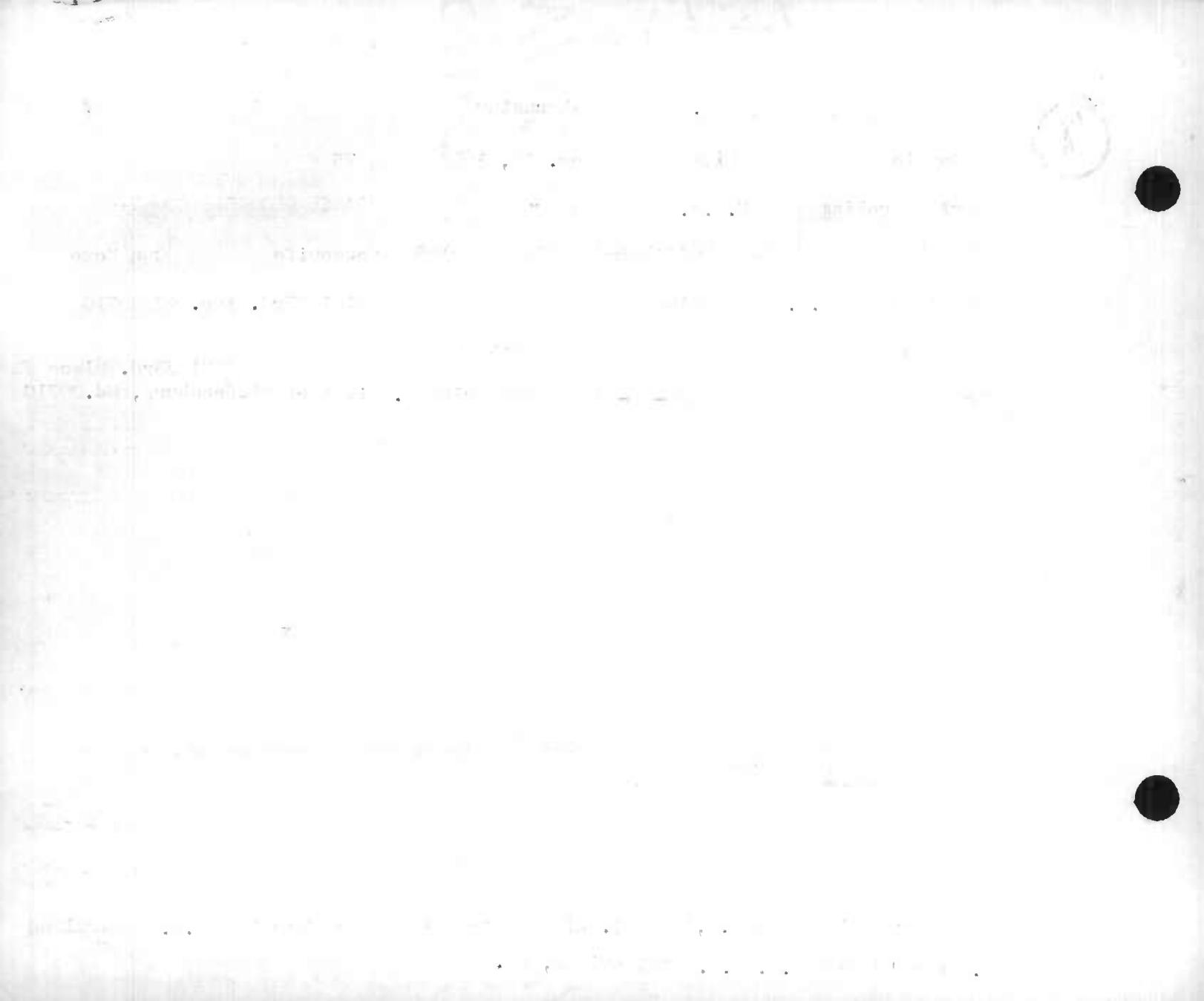
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 19 shows any injury, or other traumatic event, the medical examiner may be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 4 25427		
1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
Margaret E. Abernathy						09 04 84	2:40P M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		
Female		White		Dec. 16, 1908		75 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
North Carolina		U.S.A.				PRINCE GEORGE'S COUNTY		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
CHEVERLY		PGG HOSPITAL AND MEDICAL CENTER		Housewife		Own Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland	P.G.	Bladensburg			4101 53rd. Ave. #2 20710			
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		
Unknown				Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS 4101 53rd. Place #2		
No		216-22-0962		Katherine M. Rinehart		Bladensburg, Md. 20710		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>								
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____								
DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (he) (this hospital) attended the deceased from <i>Aug 15 1984</i> to <i>Sept 4 1984</i> , that (he) (we) lost soul the deceased alive on <i>Sent. 4 1984</i> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.								
22b. SIGNATURE <i>po-Hsia Hung</i>		DEGREE <i>12b</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9/6/84</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>po-Hsia Hung</i>		22e. ADDRESS <i>3450 Ft. Meade Rd. #207, Laurel, Md. 20707</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Sept. 7, 1984		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Crematory		23d. LOCATION Brentwood	CITY OR TOWN P.G.	COUNTY Maryland
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Md.								
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 10 1984 Julia L. Larson, R.N.								



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, LEAVE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												25428		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR		
<i>Samuel Earl ADAIR</i>						<i>19-41984</i>								
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) IN YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		
Male		black		9-30-22		61						9-5 1984 50 M		
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George</i>					
S. C			U.S.A											
10. CITY OR TOWN OF DEATH <i>Oxon Hill</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH CITY, GIVE STREET ADDRESS) <i>1100 Owens Rd</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Truck driver</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Private</i>					
13a. STATE M		13b. COUNTY P. G.		13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET ADDRESS 1100 Owen Rd		20746				
14. FATHER'S NAME FIRST <i>Henry Adair</i>			LAST			15. MOTHER'S MAIDEN NAME FIRST <i>Soungie P. Hs</i>			MIDDLE FT Washington MD					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>yes</i>			16b. SOCIAL SECURITY NO. <i>WW 2 577-22-7603</i>			17. INFORMANT <i>Virginia Jackson</i>			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <i>Chronic obstructive pulmonary disease</i> DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>														
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>														
TITLE (SPECIFY) <i>M.D. Deputy</i>														
MEDICAL EXAMINER														
ADDRESS <i>5009 Rayburn Ct., Temple Hills, Md.</i>														
23a. BURIAL, CREMATION, REMOVAL (TYPE OR CITY)			23b. DATE <i>9-8-84</i>			23c. NAME OF CEMETERY OR CREMATORIUM <i>Holmwood Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Lansdowne P. G. MD</i>					
24. FUNERAL DIRECTOR NAME <i>H. S. Washington &amp; Sons</i>			24b. ADDRESS <i>Braddocks Ave N.E.</i>			25a. DATE REC'D BY REGISTRAR <i>SEP 17 1984</i>			25b. REGISTRAR'S SIGNATURE <i>John Carson Pendell</i>					

2007-08-22 10:25:00

2007-08-22 10:25:00

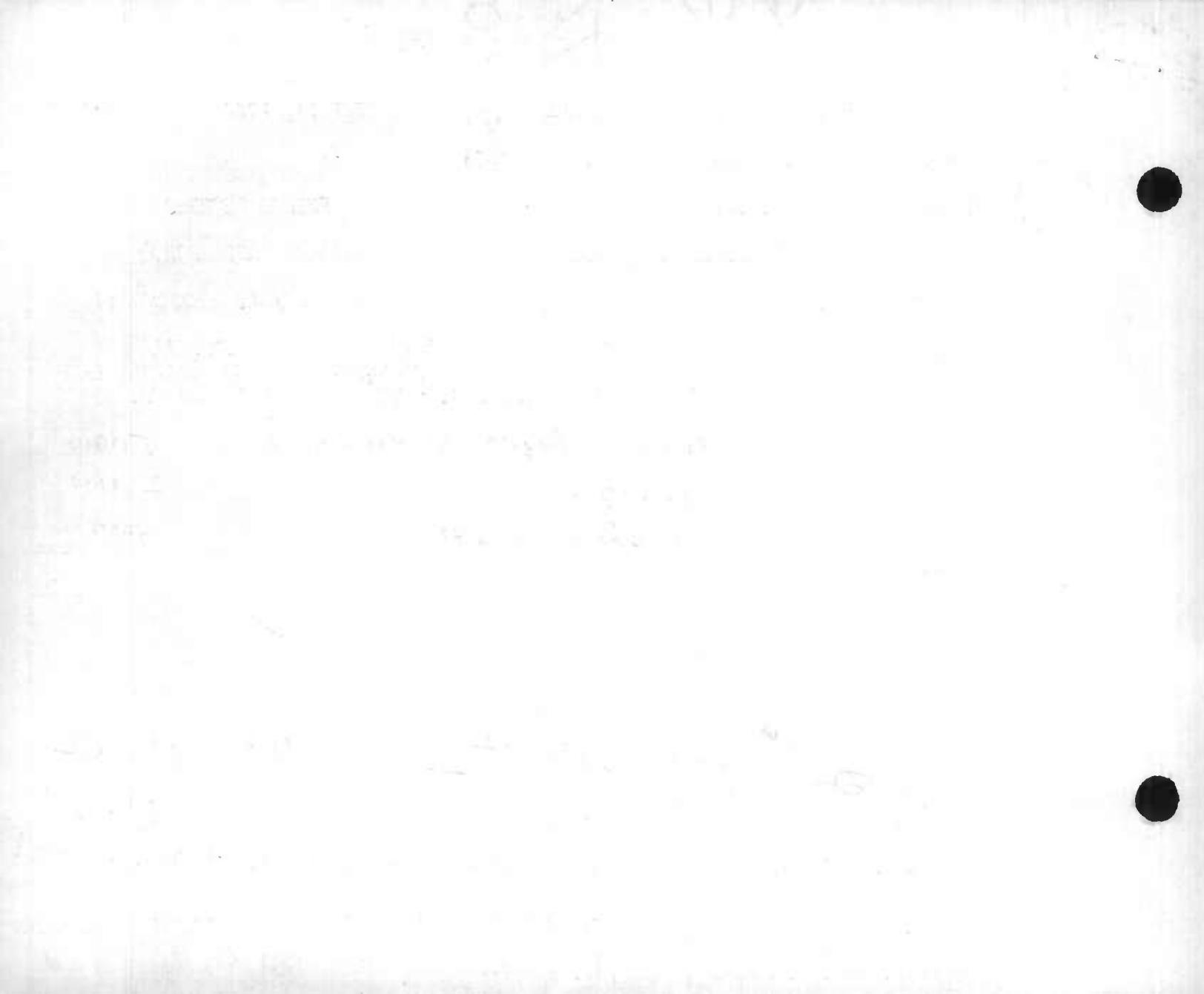
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25429			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2d. DATE OF DEATH MONTH DAY YEAR		2b. HOUR		
NELL B. ADAMS									SEPT 18, 1984		4:12 PM		
3. SEX <b>FEMALE</b>			4. RACE <b>CAUCASIAN</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>FEB 28, 1898</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b> MD.				
10 CITY OR TOWN OF DEATH <b>ADELPHI</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRESIDENTIAL WOODS</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>COLLEGE PROFESSOR</b>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>HOWARD</b>			13c. CITY OR TOWN <b>COLUMBIA</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>7080 CRADLE ROCK WAY 21045</b>		
14 FATHER'S NAME FIRST <b>JOHN</b>			MIDDLE LAST <b>BAUCOM</b>			15. MOTHER'S MAIDEN NAME FIRST <b>MARY</b>			MIDDLE		LAST <b>BUSSELL</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>252-58-3342</b>			17 INFORMANT <b>DAUGHTER</b>			ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>		
17b. SARAH A. MATE													
18 CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and 1c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Probable Aspiration Pneumonia</b>													
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Dysphagia</b>										<b>2 years</b>			
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Alzheimer's Disease</b>										<b>years</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>07/30 1982</b>			21f. LOCATION STREET <b>9/18</b> CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>07/30 1982</b> to <b>07/30 1982</b> , that (I) <b>last</b> saw the deceased live on <b>07/30 1982</b> and that in (my) <b>last</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>did not</b> view the body after death.													
22b. SIGNATURE <b>Don H. Yelonowitz, MD</b>										DEGREE <b>M.D.</b>			
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Don H. Yelonowitz, MD</b>										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. ADDRESS <b>10300 Greenbelt Rd #101 Seabrook</b>										DATE SIGNED <b>8/18/84</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>9/22/84</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>CREST LAWN CEMETERY</b>			23d. LOCATION CITY OR TOWN <b>AT LANTA</b>		COUNTY STATE <b>FULTON GEORGIA</b>		
24 FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>			ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>			25a. DATE REC'D. BY REGISTRAR <b>SEP 21 1984</b>			25b. REGISTRAR'S SIGNATURE <b>Julie Davison Pendell</b>				

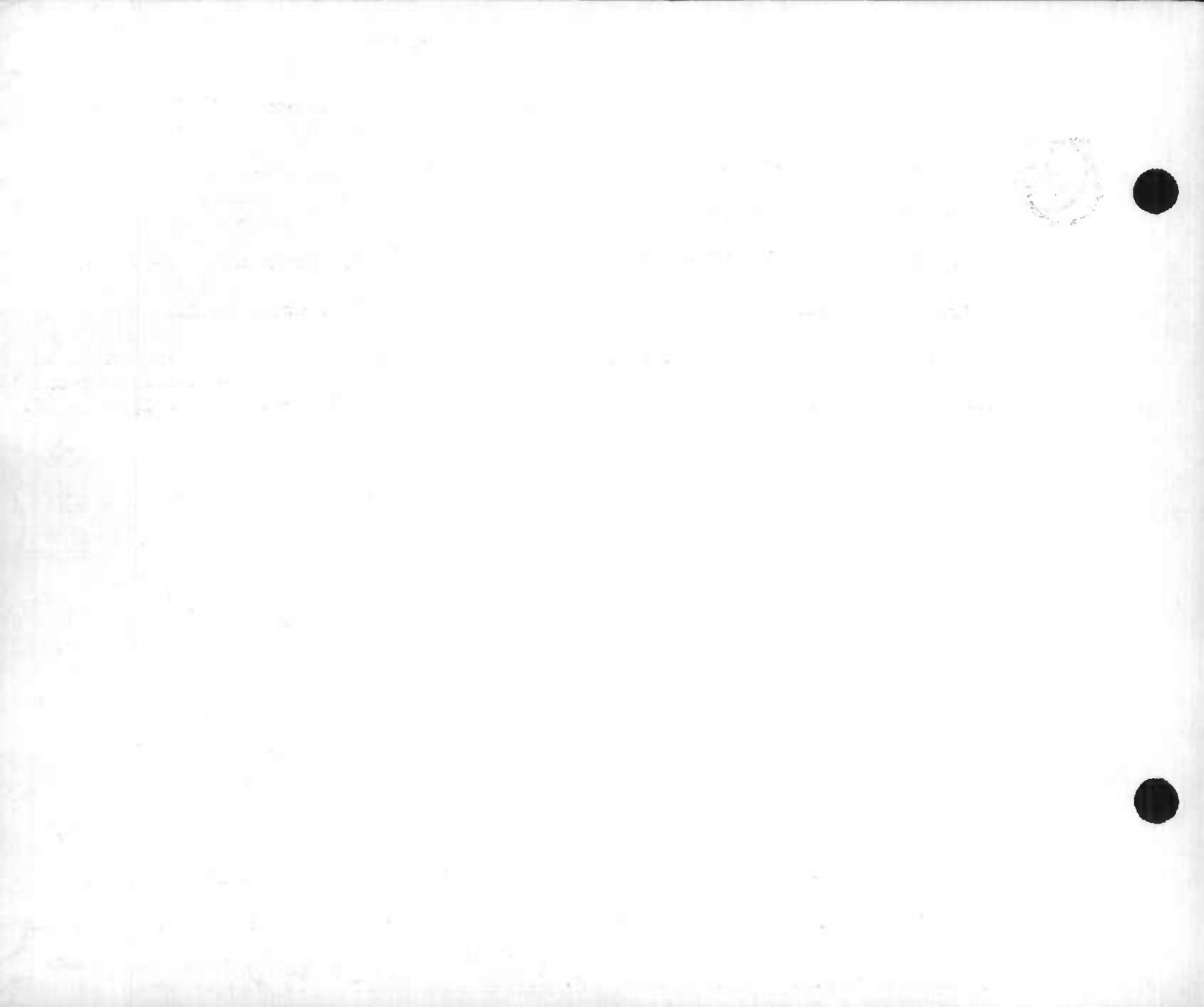


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from us as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25430	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Karl J. Ahrens						September 16, 1984						1:05P.M.	
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Male			White	MONTH	DAY	YEAR	63 YRS.			IF UNDER 74 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Germany			U.S.A.						Prince Georges				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Laurel			Greater Laurel Beltsville Hospital			Restauranteur			Self Employed				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Maryland			P.G.		Greenbelt					20910			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
Paul					Ahrens	Margarethe					Dittman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
Yes			W.W. II			Gerd H. Ahrens (Brother)			8412 Cedar Street Silver Spring, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Anik Myocarditis</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 day</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Myocarditis</i>												<i>7 year</i>	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Complications of Liver</i>												<i>12 year</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 16, 1972</i> to <i>Sep 16, 1984</i> , that (I) (we) last saw the deceased alive on <i>Sep 16, 1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <i>Robert J. McCeney, M.D.</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>9/16/84</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert J. McCeney			22e. ADDRESS 402 Main St., Laurel, Maryland 20707										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 9/19/84			23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Crematory			23d. LOCATION CITY OR TOWN Brentwood			COUNTY P.G.	STATE Maryland
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home P.A.			4739 Baltimore Avenue Hyattsville, Md. 20781			25a. DATE REC'D. BY REGISTRAR SEP 26 1984			25b. REGISTRAR'S SIGNATURE <i>John Anderson Pendell</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 25431					
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH 9-24-84							2b. HOUR 12:20 PM					
I. DECEASED NAME (TYPE OR PRINT) GEORGE Raymond Albrittain, Sr.			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR						
3. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR Oct. 3, 1908			6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.			IF UNDER 1 YEAR MONTHS DAYS		# UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE George's MD.						
10. CITY OR TOWN OF DEATH Clinton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md. Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist			12b. KIND OF BUSINESS OR INDUSTRY N.O.S.						
13a. STATE Maryland			13b. COUNTY Charles			13c. CITY OR TOWN Marbury			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Rt. 1, Box 277, 20658			
14. FATHER'S NAME FIRST MIDDLE LAST George Ernest Albrittain			15. MOTHER'S MAIDEN NAME Maggie												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 216-07-9821			17. INFORMANT (Wife) Annie Mae Albrittain, Same as Line 13			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-Pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF HYPTENSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF CEREBRAL HAEMORRHAGE (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b MENINGITIS															
19a. DATE OF OPERATION 9/11/84			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cerebral Haemorrhage			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 8/31/84 to 9/24/84, that (I) (we) lost saw the deceased alive on 9/24/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE D. Seet Ramayya			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9/24/84						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SEETARAMAYYA NAGULU			22e. ADDRESS WALDORF, MD 20601.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-26-84			23c. NAME OF CEMETERY OR CREMATORIAL Trinity Mem. Gdns.			23d. LOCATION CITY OR TOWN WALDORF, Charles, P.G.			COUNTY STATE			
24. FUNERAL DIRECTOR NAME Hunt Funeral Home, Waldorf, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR SEP 26 1984			25b. REGISTRAR'S SIGNATURE						
DHMH - 16 50M 4/B3 (VRA 15, 4)															

A

48-35-2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Postage may be paid by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**MEDICAL CERTIFICATION**

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 25432								
1 - FOR STATE REGISTRAR				2a DATE OF DEATH MONTH DAY YEAR						2b HOUR								
1. DECEASED NAME (TYPE OR PRINT)				FIRST <b>Joseph</b>	MIDDLE <b>nmm</b>	LAST <b>Anarado</b>	September 8, 1984						1:47a M					
3. SEX <b>Hale</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR								
				September 7, 1984									MONTHS DAYS HOURS MIN					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b>			10. CITY OR TOWN OF DEATH <b>Clinton</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hospital Center</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a STATE <b>Maryland</b>		13b COUNTY <b>PG</b>		13c CITY OR TOWN <b>Forestville</b>			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS <b>6128 Surray Square Lane</b>			20735					
14. FATHER'S NAME FIRST <b>Paul</b>		MIDDLE <b>Udoka</b>		LAST <b>Anarado</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Felicia</b>			MIDDLE <b>Ogiageli</b>			LAST <b>Onuorah</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b SOCIAL SECURITY NO. (IF YES GIVE WAR OR DATES)		n/a			17 INFORMANT <b>X Felicia Anarado</b>			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18 CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe immaturity (20 wks)</b> DUE TO, OR AS A CONSEQUENCE OF <b>cardio-respiratory arrest</b>																		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from _____ 19 _____, to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <b>Carmen E. Enecio</b> DEGREE																		
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>																		
22c. ADDRESS <b>7503 Surratts Road Clinton, Maryland 20735</b>																		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Carmen E. Enecio</b>																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>9/13/84</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>So. Md. Hosp. Center</b>			23d. LOCATION CITY OR TOWN <b>Clinton</b>		23e. COUNTY <b>P.G.</b>		23f. ST. NO. <b>MD.</b>							
24 FUNERAL DIRECTOR NAME <b></b>		ADDRESS		25a. DATE REC'D. BY REGISTRAR <b>SEP 14 1984</b>			25b. REGISTRAR'S SIGNATURE <b>Julie Davidson-Randall</b>											
DHMH - 16 50M 1/81 (VRA 15, 4)																		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

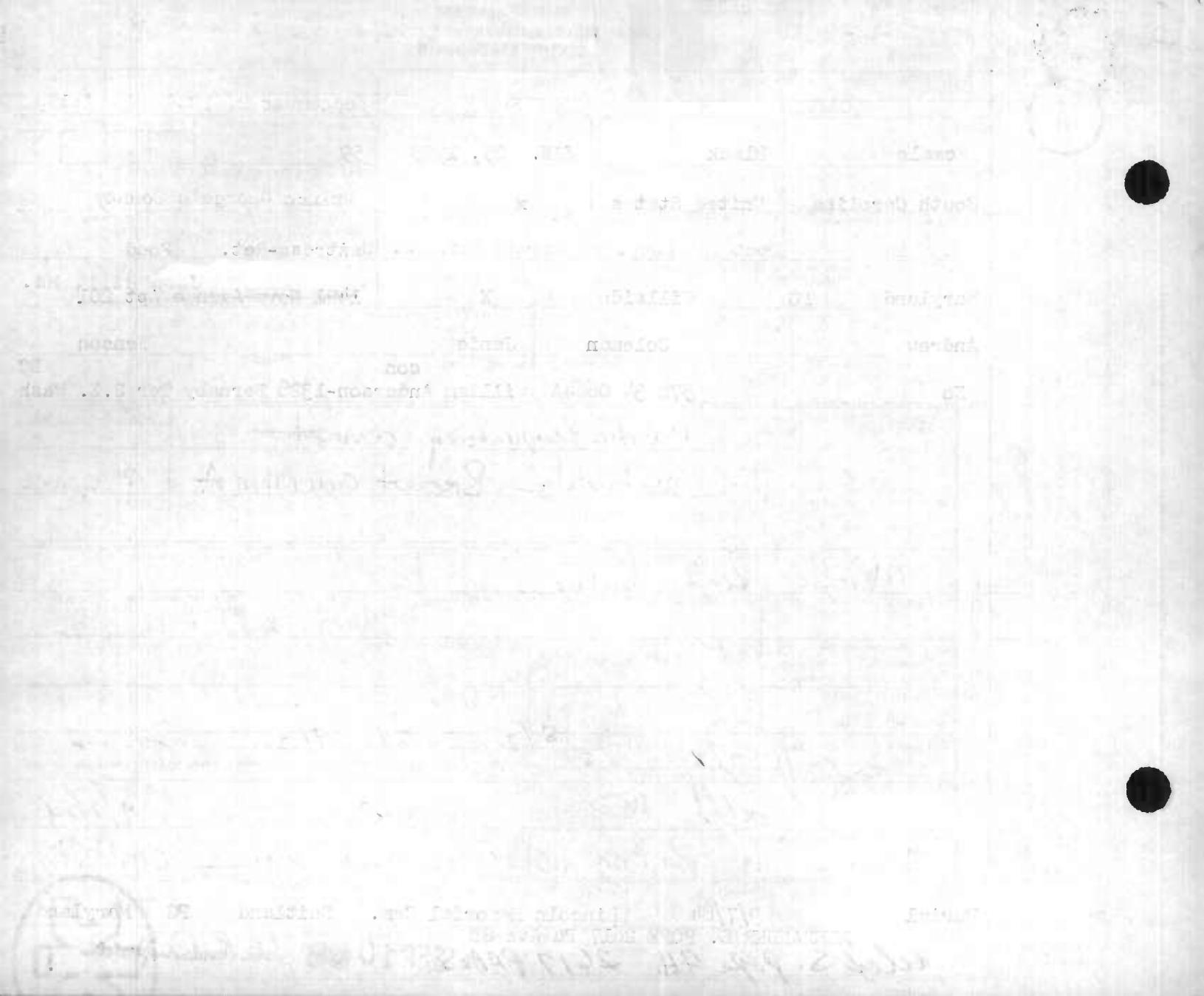
Item 13e, per FH call  
FOR 12-12-84jlb  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

25433

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
CARRIE B ANDERSON						September 2, 1984				1:19 p.m.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		# UNDER 24 HRS		
Female		Black		MONTH JAN.	DAY 25	YEAR 1925	59	YEARS	MONTHS	DAYS	HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
South Carolina		United States				Prince George's County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Lanham		Doctors' Hosp. of Prince Geo. Co.		Waitress-Ret.		Food					
13a. STATE Maryland			13b. COUNTY PG	13c. CITY OR TOWN Hillside		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1100 Owens Rd Oxon Hill Md.			
								1421 Nova Avenue Apt 201			
14. FATHER'S NAME FIRST Andrew		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Janie		MIDDLE	LAST Benson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT son		ADDRESS					
No		578 34 0664A				William Anderson-1328 Barnaby Ter S.E. Wash DC					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Breast carcinoma A 2 years											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. Chronic renal failure											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (b) this hospital attended the deceased from now the deceased died on 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) this did (did not) view the body after death.		8/2 19 84 to 7/2 19 84									
22b. SIGNATURE <i>S. Hall</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/2/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Steven M. Pollak MD</i>		22e. ADDRESS <i>4700 Ruth Place Catonsville</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/7/84		23c. NAME OF CEMETERY OR CREMATORIUM Lincoln Memorial Cem.		23d. LOCATION CITY OR TOWN Suitland		COUNTY PG		STATE Maryland	
24. FUNERAL DIRECTOR ALEXANDER S. POPE 2617 Pa Ave SE NAME: <i>Alex S. Pope Jr.</i> ADDRESS: <i>2617 PA Ave SE EP 10</i>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>Jane Davidson Pendell</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, it should be forwarded for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on item 21.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25434	
												REG. NO.	
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Fairbanks NMI			AUSTIN			September 23, 1984			2:08 AM	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Male			White			Feb. 25, 1905			79			MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS	
Virginia			U.S.A.						Prince George's MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Lanham			Doctor's Hospital of p.g.			Carpenter			G.S.A.				
USUAL RESIDENCE IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION													
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Lanham		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 9114 Annapolis Rd. 20706				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME Emma Bowman										
Nathan B. Austin													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. 220 26 4681A			17. INFORMANT Lena Austin			ADDRESS 9114 Annapolis Road Lanham, Md. 20706			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Acute Respiratory failure										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia and chronic obstrucive Lung Disease and (c) Congestive cardiac failure										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 09/19/84 to 09/23/84, that (I) (we) last saw the deceased alive on 09/22/84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE M.Karim			22c. DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22d. DATE SIGNED 09-23-84				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) MoBARAK KARIM			22f. ADDRESS #206 LANDOVER MALL WEST, LANDOVER, MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/25/84			23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery			23d. LOCATION CITY OR TOWN Brentwood, Md.			COUNTY STATE	
24. FUNERAL DIRECTOR NAME Francis Gasch's Sons F.H. P.A.			4739 Baltimore Ave			25a. DATE REC'D. BY REGISTRAR SEP 26 1984			25b. REGISTRAR'S SIGNATURE Julie Davidson Pendell				

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200 ft. below ground surface  
water level about 100 ft.  
below surface of lake

X

18.5' 18.7' 18.9'

18.5'-19.

X 18.7' 18.9'

18.9' - 19.1' 19.2' 19.3' 19.4' 19.5'

MAX. GRAVITY

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 5-135			
1. STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				LAST				2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR OF ESTI. DEATH MATED <input checked="" type="checkbox"/> 9-24 1984				2b. HOUR MONTH DAY YEAR 2d HOUR	
		Lonnie A. Barrs													
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS (LAST BIRTHDAY) YRS.)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD 9-24 1984		5:15 p.m.	
MALE		WHITE		March 3, 1948		36									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		U.S.A.								Prince George's County, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Brandywine		1310 13th St. - Cedarville				CONSTRUCTION				PVT.					
13. STATE MARYLAND		13b. COUNTY PRINCE GEORGE		13c. CITY OR TOWN BRANDYWINE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 10505 Cedarville Rd. 13-11							
14. FATHER'S NAME WILLIAM		MIDDLE B.		LAST BARRS <sup>ST</sup>		15. MOTHER'S MAIDEN NAME DORIS				LAST H. DOVE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS							
NO		577-66-5344		Mrs. Lois J. Barrs, same as #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) Hanging DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY est. HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR 3:30 P.M. 9-24 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject hung himself				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) trailer		21f. LOCATION STREET 1310 13th St. - Cedarville, Brandywine, Prince George's Co., Md.				CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE Dennis F. Smyth, M.D. M.D. ASSISTANT MEDICAL EXAMINER															
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St., Balto., Md. 21201				DATE SIGNED 9-25-84									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Sept. 28, 1984		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery				23d. LOCATION CITY OR TOWN Suitland, P.G., Maryland							
BURIAL															
24. FUNERAL DIRECTOR NAME LEE FUNERAL HOME, 6633 Old Alex- ander Ferry Rd., Clinton, Maryland						25a. DATE REC'D. BY REGISTRAR OCT 2 1984		25b. REGISTRAR'S SIGNATURE June Davidson-Pendell							
BP															
DHMH - 17 (VR A15 ME (5)) 20M 4/82															

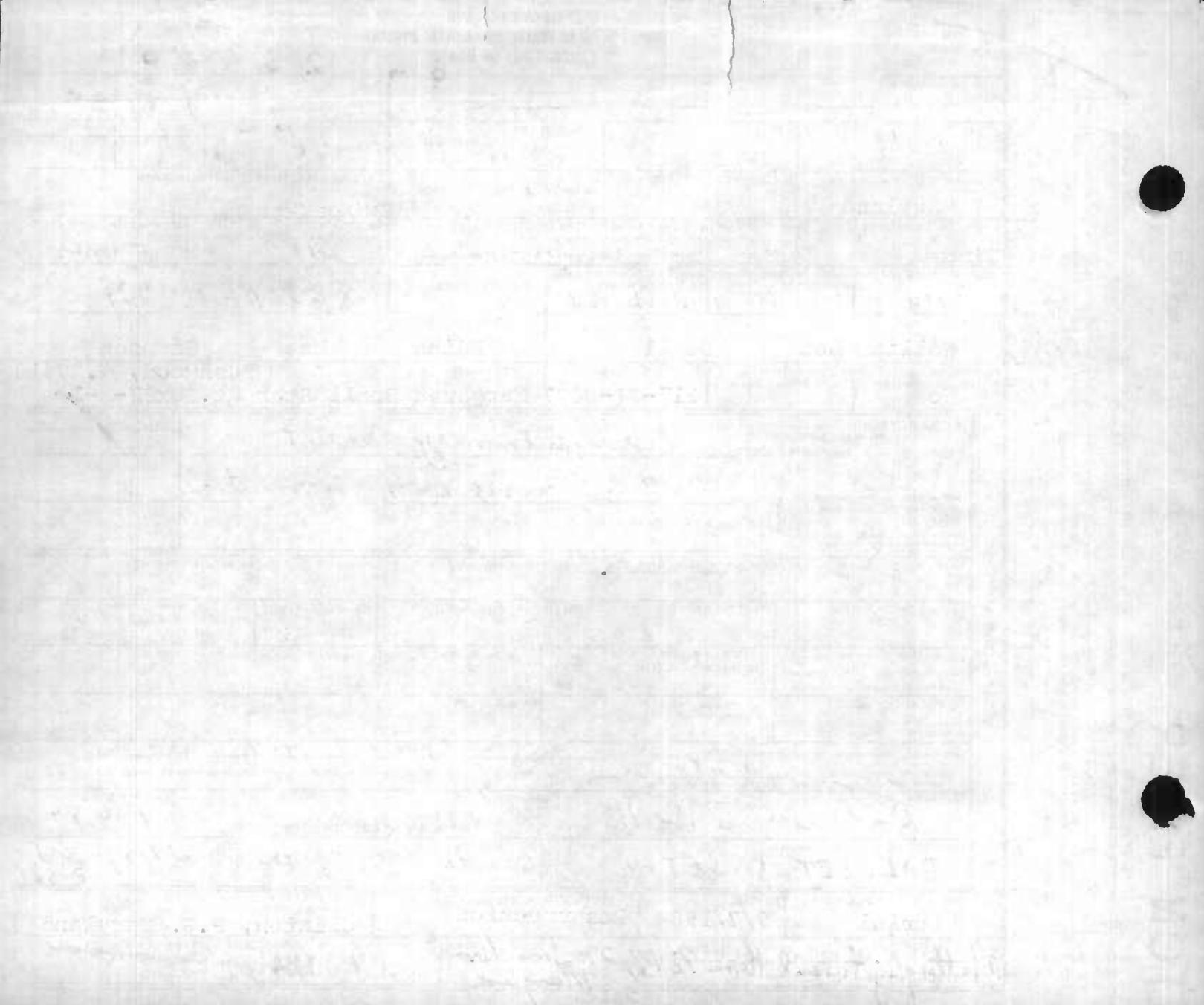


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner should be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 25436
1. DECEASED NAME (TYPE OR PRINT)			2. DATE OF DEATH MONTH DAY YEAR			2b. HOUR
GEORGE EARL BEALL Sr			9 4 84			3:08 PM
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>9 19 36</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>48</i>		6c. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i>		
10. CITY OR TOWN OF DEATH <i>Clinton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Southern Maryland Hospital Center</i>			12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Sell</i>	
13a. STATE <i>Md</i>	13b. COUNTY <i>St. Mary</i>	13c. CITY OR TOWN <i>Bushwood</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>Star Route 237</i>	
14. FATHER'S NAME FIRST: William Leo MIDDLE: Beall LAST:			15. MOTHER'S MAIDEN NAME FIRST: Edith MIDDLE: Mae LAST: Simpson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>	16b. SOCIAL SECURITY NO. <i>217-34-0497</i>	17. INFORMANT <i>Margaret Beall Star Rt. Box 32-A-1</i>		ADDRESS: Bushwood, Md. 20618		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiopulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Brain mass with Herniation</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>9-3-84</i> to <i>9-4</i> , 1984, that (I) (we) last saw the deceased alive on <i>9-3-84</i> , 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Baljeet S. Sethi</i>			DEGREE	22c. DATE SIGNED <i>9-4-84</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BALJEET S. SETHI</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22e. ADDRESS <i>Charles Proj. centre, Waldorf, Md 20601</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/7/1984	23c. NAME OF CEMETERY OR CREMATORIAL Resurrection	23d. LOCATION CITY OR TOWN Clinton, P.G. Maryland	23e. COUNTY	STATE	
24. FUNERAL DIRECTOR <i>N. Clarke Mattingley</i>	27a. DATE REC'D. BY REGISTRAR SEP 7 1984	25b. REGISTRAR'S SIGNATURE <i>John Dawson-Mattingley</i>				
Mattingley Funeral Home 70152 Maryland 20650						

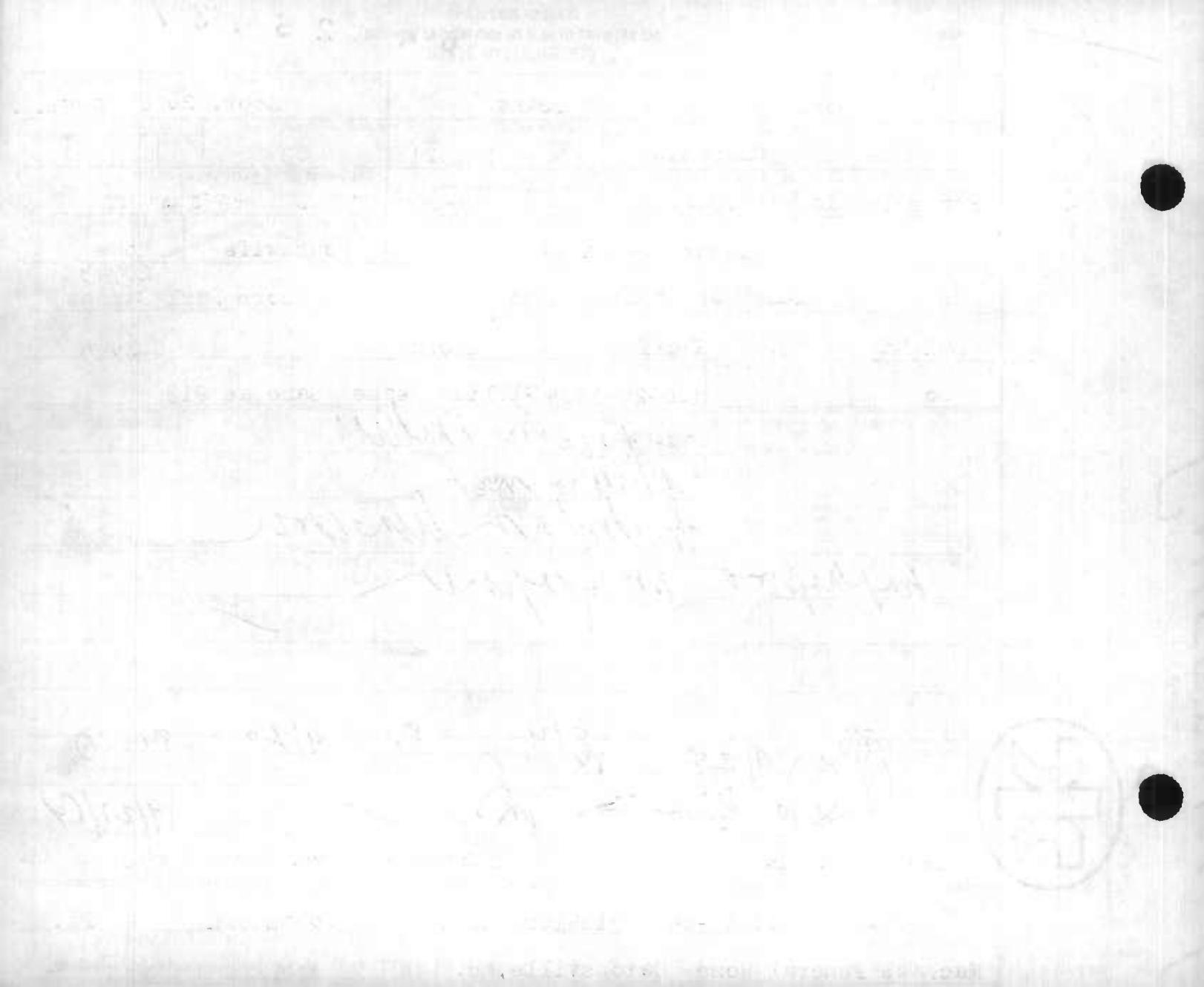


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use on the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, she immediate attention must be afforded at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25437	
												REG. NO.	
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			14. DATE OF DEATH MONTH DAY YEAR			28. HOUR	
			Dorothy Jean Beane						Sept. 26 84			8:05p.m.	
1. SEX			2. RACE			3. DATE OF BIRTH MONTH DAY YEAR			4. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Female			Caucasian			4 2 1921			63			IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD	
Pennsylvania			U.S.A.						PRINCE GEORGE'S COUNTY				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13. KIND OF BUSINESS OR INDUSTRY				
LANHAM			Doctors Hospital			Housewife			Home				
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Md			13b. COUNTY Prince Geo Capital Hts			13d. INSIDE CITY LIMITS? No <input type="checkbox"/>			13e. STREET ADDRESS 9529 Acorn Park Street			20743	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Dwight R. Shaffer			Ilona									Unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
			160-20-5385			Williad Beane			Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for item 18a, b, c, d, e, f, g, h, i, j, k, l, m, n, o, p, q, r, s, t, u, v, w, x, y, z.) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a):												APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>hypertension</i>													
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>myocardial infarction</i>													
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION OR WHICH OPERATION WAS PERFORMED			20b. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21, PART 1 OF PART 2)							
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) this hospital attended the deceased from <u>6/14</u> to <u>9/26</u> , 19 <u>84</u> , to <u>1984</u> , that (I) we last saw the deceased alive on <u>9/25</u> , 19 <u>84</u> and that (I) my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, check here) <input type="checkbox"/>													
22b. SIGNATURE <i>Lewis H. Dennis</i>			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22d. DATE SIGNED <i>9/27/84</i>				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis H. Dennis, MD			22f. ADDRESS 831 University Blvd. Silver Spring, MD 20906										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-1 -84			23c. NAME OF CEMETERY OR CREMATORIAL Richland Cem.			23d. LOCATION CITY OR TOWN Johnstown			COUNTY STATE Pa.	
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home			ADDRESS Catonsville, Md.			25a. DATE REC'D. BY REGISTRAR OCT 2 1984			25b. REGISTRAR'S SIGNATURE <i>Susan Davidson Pendell</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3 should be detached for use on the burial permit). Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 4.

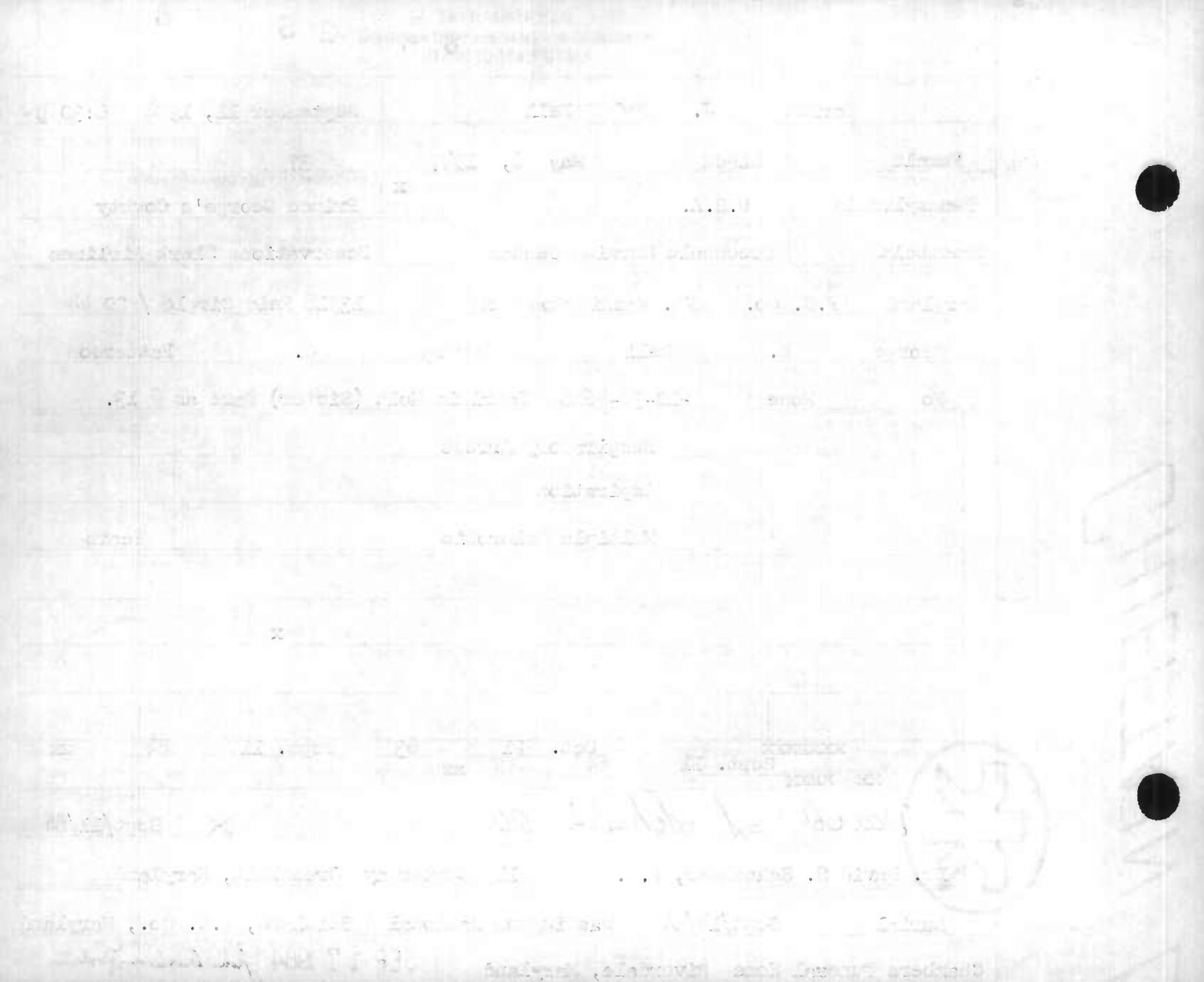
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

2 5 4 3 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Carmen	MIDDLE J.	LAST Bell	2a. DATE OF DEATH MONTH September	DAY 11	YEAR 1984	2b. HOUR 6:30 p m		
3. SEX Female			4. RACE Black		5. DATE OF BIRTH MONTH May	DAY 6	YEAR 1947	6. AGE (IN YEARS LAST BIRTHDAY) 37 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.				
10. CITY OR TOWN OF DEATH Greenbelt			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greenbelt Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Reservations Clerk Airlines				12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY P.G. Co.	13c. CITY OR TOWN Ft. Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13518 Reid Circle / 20744				
14. FATHER'S NAME FIRST George			MIDDLE E.	LAST Bell	15. MOTHER'S MAIDEN NAME Carmen		16. ADDRESS C. Patterson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT Patricia Holt (Sister) Same as # 13.		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Respiratory Arrest								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			(b) Aspiration								
			(c) Multiple Sclerosis				Years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED <small>AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></small>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) <input checked="" type="checkbox"/> <small>physician</small> attended the deceased from Oct. 21 19 83 to Sept. 11 19 84, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on Sept. 11 19 84, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> did <input checked="" type="checkbox"/> not <input type="checkbox"/> view the body after death.											
22b. SIGNATURE <i>David S. Schachter</i>			DEGREE 00		ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED Sept/11/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. David S. Schachter, M.D.			22e. ADDRESS 115 Centerway Greenbelt, Maryland								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept/14/84	23c. NAME OF CEMETERY OR CREMATORIAL Washington National		23d. LOCATION CITY OR TOWN Suitland, P.G. Co., Maryland		25a. DATE REC'D. BY REGISTRAR SEP 17 1984			
24. FUNERAL DIRECTOR NAME Chambers Funeral Home			ADDRESS Riverdale, Maryland					25b. REGISTRAR'S SIGNATURE <i>John Davidson Pendleton</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25439		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Jacqueline Elainx Bennett						9-18-84			4:25 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female		White		9 14 84			-			YRS. 4 24 45		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA					Cheverly			Pr. Geo. MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly		Prince Georges General Hospital		None								
13a. STATE Md.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Hy.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS (20782) 2004 - Powhatan Road		
14. FATHER'S NAME FIRST John P. MIDDLE Bennett, Jr. LAST		15. MOTHER'S MAIDEN NAME FIRST Janis MIDDLE LAST Smith										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			18. ADDRESS			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No		None		John P. Bennett, Jr.								
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>Anencephaly</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) _____												
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c) _____												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>9-14-84</u> to <u>9-18-84</u> , that (I) (we) last saw the deceased alive on <u>9-18-84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Paulito David Tugan</u>		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED <u>9-18-84</u>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>PAULITO DAVID TUGAN</u>		22f. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-20-1984		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cem.			23d. LOCATION CITY OR TOWN Brentwood		COUNTY Pr. Geo. Md.		STATE	
24 FUNERAL DIRECTOR NAME Nalley's F.H. Inc.		ADDRESS Mt. Rainier, Md.					25a. DATE REC'D. BY REGISTRAR SEP 24 1984		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson Pendell</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on item 18, sign any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 25440
1. DECEASED NAME (TYPE OR PRINT) <b>Ruth M. Benson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 12, 1984</b>	2b. HOUR <b>4:40 A.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 1 1897</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>87 YRS.</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE COUNTRY <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's MD.</b>	
10. CITY OR TOWN OF DEATH <b>Laurel</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Laurel Beltsville Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montg</b>	13c. CITY OR TOWN <b>Burtonsville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>3109 Bryan Rd. 20866</b>
14. FATHER'S NAME <b>Harry</b>		MIDDLE <b>--</b>	LAST <b>Stanton</b>	15. MOTHER'S MAIDEN NAME <b>Ruth</b>	MIDDLE <b>Fisher</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT ADDRESS <b>Joy White Same as #13e</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC RESPIRATORY ARREST</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF (b) <b>CEREBROVASCULAR ACCIDENT</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 9/6 84		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 9/84	21f. LOCATION STREET CITY OR TOWN COUNTY STATE 9/11 88		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <i>Mark Parkhurst</i>		DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>9/12</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARK PARKHURST M.D.</b>		22e. ADDRESS <b>7100 BALT. AVE CALIFORNIA PARK</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/13/84</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Union Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY <b>Burtonsville Md.</b>	
24. FUNERAL DIRECTOR NAME <b>FLECK FUNERAL HOME INC.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 17 1984</b>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pandell</i>	
ADDRESS <b>7601 Sandy Spring Rd. Laurel, Md. 20707</b>					

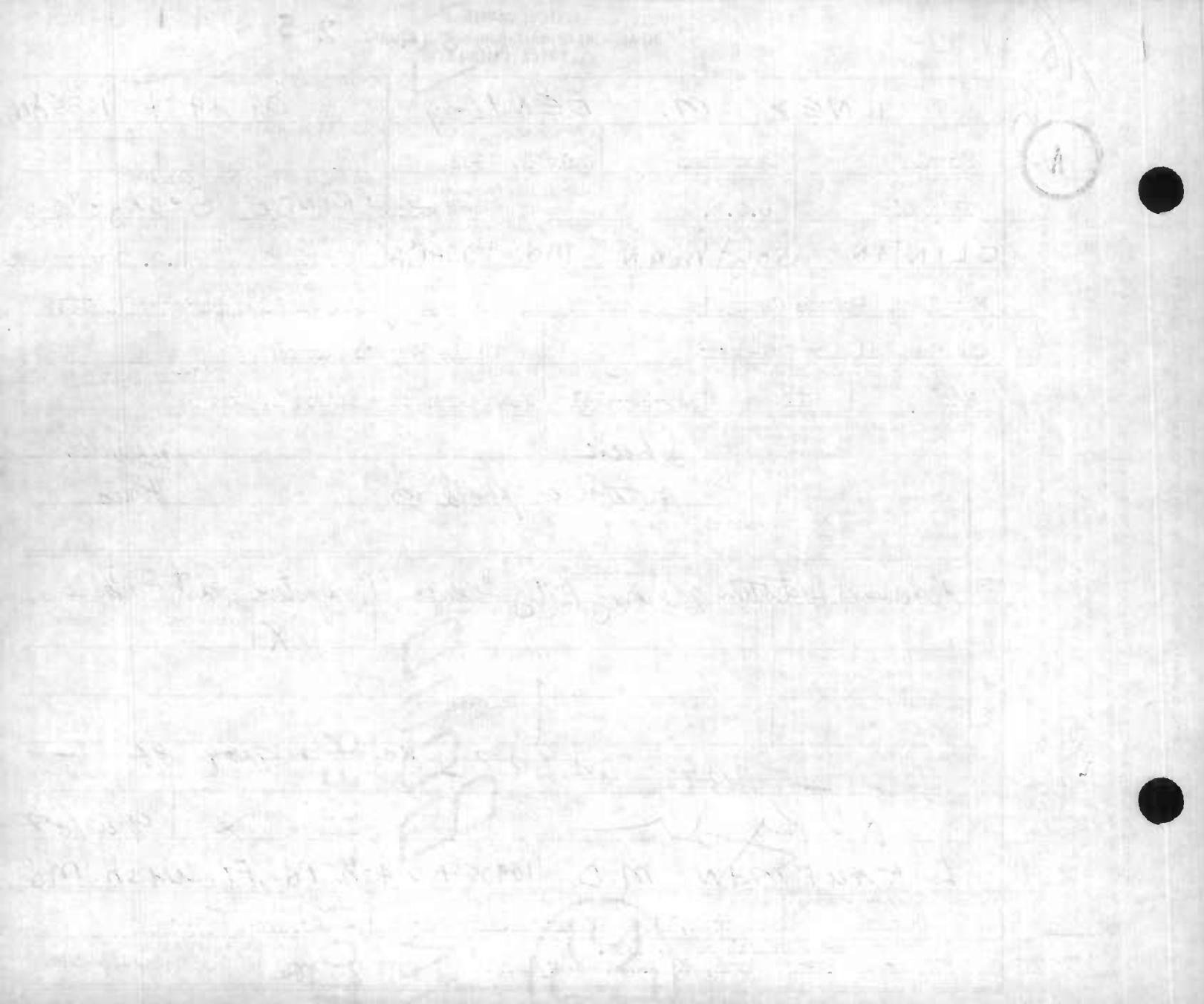
1990-34100 2000-007 66-70244248 2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 16 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25441			
										REG. NO.			
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		09 29 84		1:35 AM		
INEZ m. BENTLEY													
3 SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois			7b CITIZEN OF WHAT COUNTRY? U.S.A.			7c MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8 81 YRS			9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE George's MD.	
10 CITY OR TOWN OF DEATH CLINTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Md. Hospital Clerical			12b. KIND OF BUSINESS OR INDUSTRY U.S. Government				
13a. STATE Maryland			13b. COUNTY Prince George			13c. CITY OR TOWN District Heights			13d. INSIDE CITY LIMITS? NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 6501 Kipling Parkway (20747)	
14 FATHER'S NAME Charles William Griesmer			15. MOTHER'S MAIDEN NAME Ollie May Mc Durman										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b SOCIAL SECURITY NO. WWII			17 INFORMANT Jean Bennett - Route 2, Box 535HH			ADDRESS Silver Spring, FLA			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Hours	
18 CAUSE OF DEATH (Enter only one cause per line for Part I, and Part II.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b) Metabolic Acidosis										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>Abdominal Distention; Coronary Artery Disease; Congestive Heart Failure</i>												20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21, PART I, OR PART II)			21d. AUTOPSY			21e. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21d. LOCATION STREET CITY OR TOWN COUNTY STATE				
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>													
22a. I certify that (1) (this hospital) attended the deceased from <u>7/29/84</u> to <u>8/29/84</u> , that in (my) ( <input type="checkbox"/> ) opinion death occurred on the date and hour and from the causes stated above. (1) ( <input type="checkbox"/> ) did ( <input type="checkbox"/> ) view the body after death.												22b. DATE SIGNED 9/29/84	
22c. SIGNATURE <i>L. KAUFMAN M.D.</i>			22d. DEGREE			22e. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22f. ADDRESS 10905 Ft. Wash. Rd., Ft. Wash. Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE October 2, 1984			23c. NAME OF CEMETERY OR CREMATORIAL Resurrection Cemetery			23d. LOCATION Clinton, Maryland				
24. FUNERAL DIRECTOR Lee Funeral Home, Inc. Old Alexander Ferry Road, Clinton, Maryland						25a. DATE REC'D. BY REGISTRAR OCT 2 1984			25b. REGISTRAR'S SIGNATURE <i>Julia Dawson-Randall</i>				
DHMH - 16 50M 6633 (VRA 15, 4)													



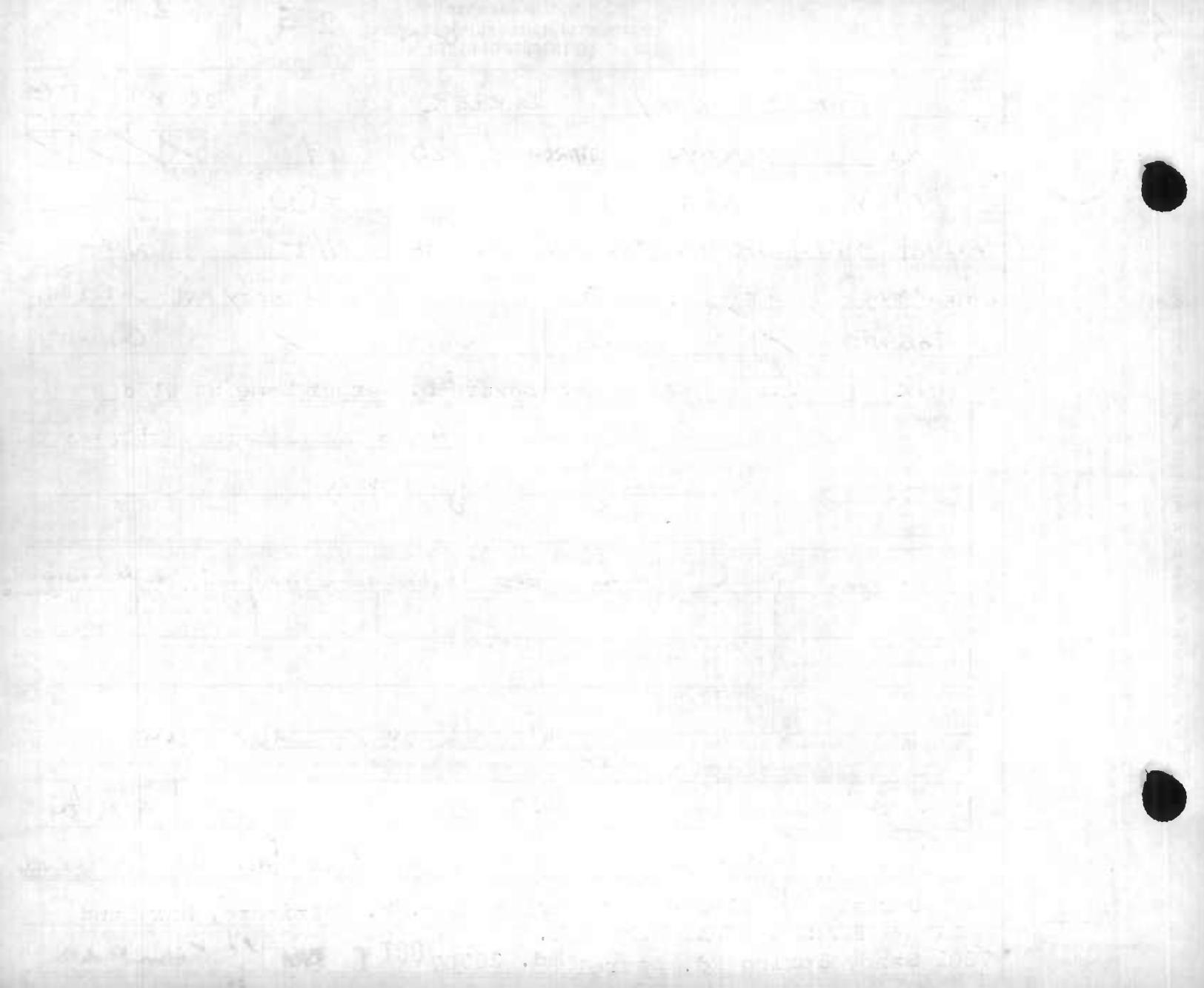
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 above any injury or other traumatic event, the medical examiner will be called in to make a postmortem examination.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 25442	
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 9 25 84							2b. HOUR 11 59 AM	
1. DECEASED NAME (TYPE OR PRINT)		FIRST FRANCES	MIDDLE MARY	LAST BERGER			6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS				
3. SEX FEMALE		4. RACE ITALIAN		5. DATE OF BIRTH MONTH MARCH DAY 31 YEAR 20			7. AGE (IN YEARS LAST BIRTHDAY) 64 YRS				
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ITALY		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			11. BALTIMORE CITY OR COUNTY OF DEATH PG CO.		12. IF UNDER 1 YEAR MONTHS DAYS HOURS MINUTES		
13. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADV. HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A			12b. KIND OF BUSINESS OR INDUSTRY N/A		MD. 20707		
13a. STATE MARYLAND		13b. CITY OR TOWN LAUREL		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 12 Murray Ave, Laurel MD				
14. FATHER'S NAME DOMINIC		15. MOTHER'S MAIDEN NAME GRECO NANCY		16. SOCIAL SECURITY NO. 133-03-3472			17. INFORMANT Edward D. Berger Same as #13e		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK		16b. IMMEDIATE CAUSE (a) Cardiac collapse		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac collapse							
		18. DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease									
		18. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. Seizure renal failure hypertension cerebrovascular malignant neoplasm											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
19b. YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED # WHILE WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9/25/84 to 9/25/84, that (I) (we) last saw the deceased alive on 9/25/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dennis Friedman		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 9/25/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DENNIS FRIEDMAN		22e. ADDRESS 13-15 EAST Deer Park Dr, Gaithersburg									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/29/84		23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Mem. Pk.			23d. LOCATION CITY OR TOWN Baltimore, Maryland		23e. COUNTY STATE		
24. FUNERAL DIRECTOR FLECK FUNERAL HOME INC. NAME ADDRESS 7601 Sandy Spring Rd. Laurel Md. 20707										25a. DATE REC'D. BY REGISTRAR OCT 1 1984	25b. REGISTRAR'S SIGNATURE Linda Rendell

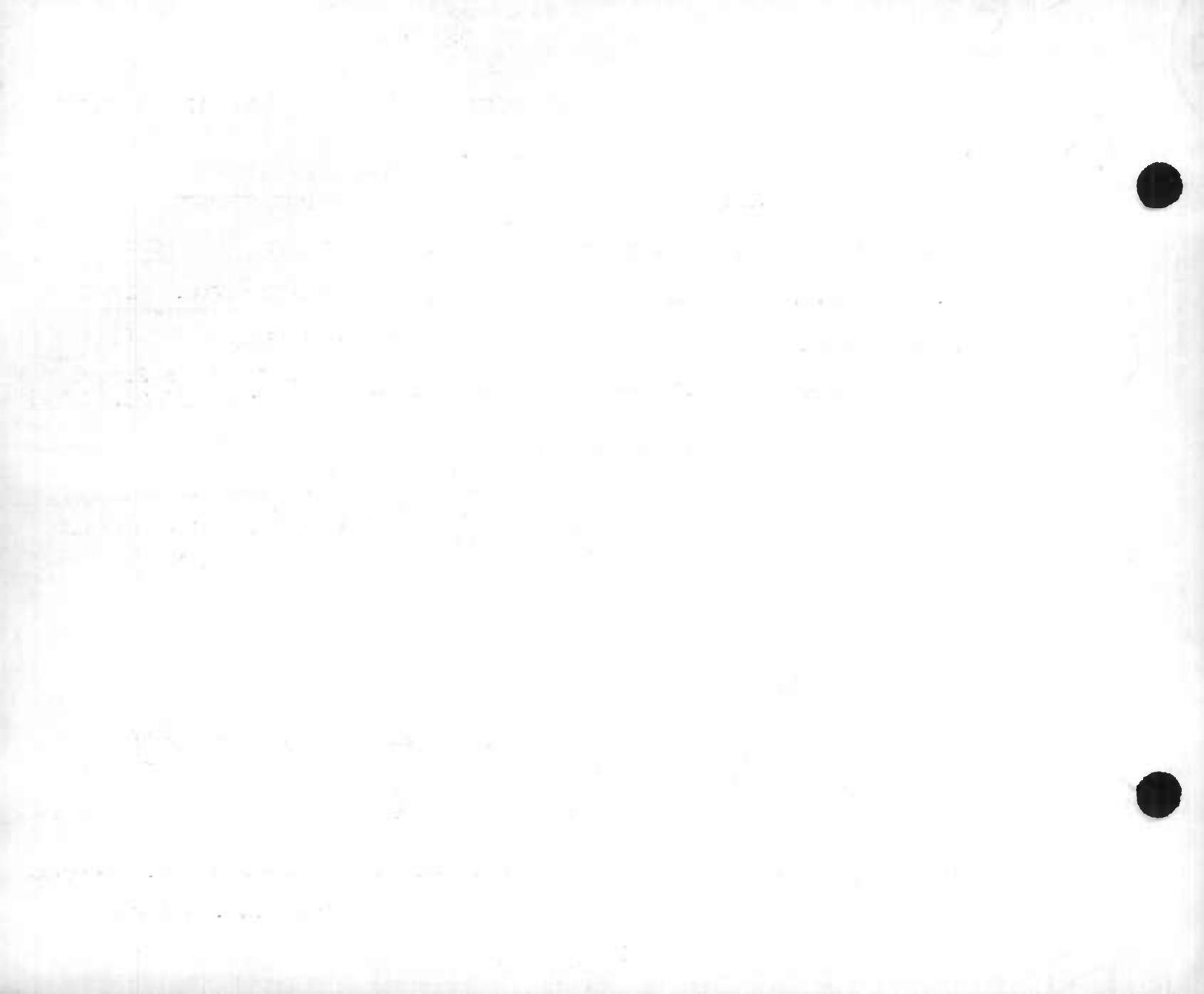


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25443							
										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR			
LOUISE						BERNARDON			09		17	84	6:50P M				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS						
Female		White		Month October Day 26 Year 1903			81 YRS.		MONTHS DAYS		HOURS MIN.						
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
Italy		Italy					PRINCE GEORGES			MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
CHEVERLY		PRINCE GEORGES GENERAL HOSPITAL			Homemaker			None									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13e. STREET ADDRESS / ZIP CODE							
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Hillside			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1129 Lago Ave. 20743								
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST														
Enrico Manarian			Teresa Toffolo														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS								
No None			577-84-3018			Robert Bernardon			3423 Welthem Street Silver Hill Md. 20746								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
(b) DUE TO, OR AS A CONSEQUENCE OF Cerebral Vasculitis accident																	
(c) DUE TO, OR AS A CONSEQUENCE OF Cerebral infarct Inappropriate Antidiuretic Hormone -																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9-10 1984 to 9-17 1984, that (I) (we) last saw the deceased alive on 9-17 1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		9-18-84					
Mushtaq Shah MD.			4637 Eastern Ave. MT. Rainier MD 20712														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/20/84			23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery			23d. LOCATION CITY OR TOWN Clinton P.G. Maryland		COUNTY		STATE				
24. FUNERAL DIRECTOR NAME Lee Funeral Home Inc. ADDRESS			25a. DATE REC'D. BY REGISTRAR SEP 20 1984			25b. REGISTRAR'S SIGNATURE Lee Bernardon											
6633 Old Alexander Ferry Road Clinton, Maryland 20735																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the medical certificate must be signed by a physician.

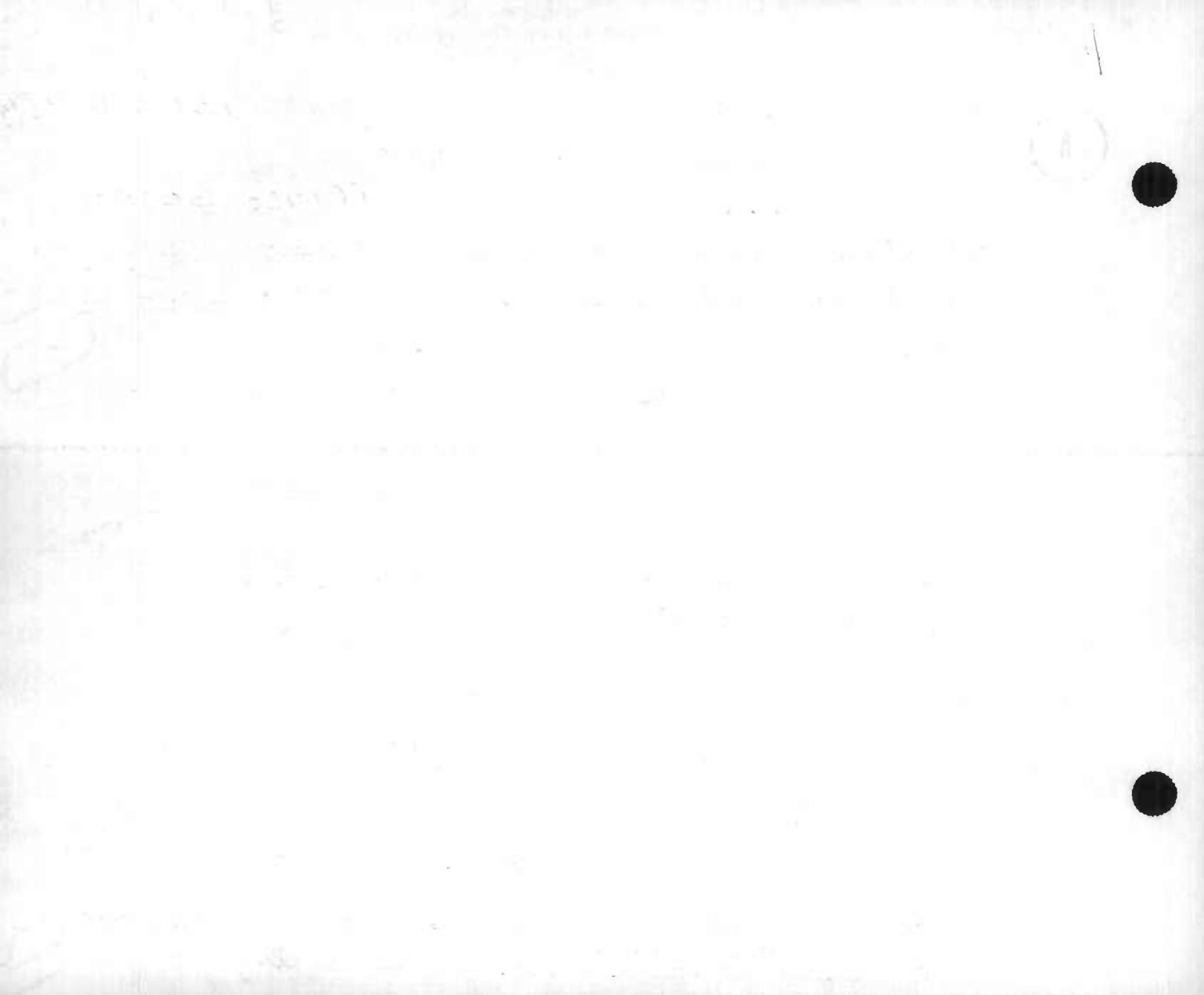
## MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

2544

REG. NO.

1. DECEASED NAME <small>TYPE OR PRINT</small>			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
MARY LOUISE BLOMGREN						SEPTEMBER	13	1984		11:39 PM			
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		September 23, 1916		67	YRS.	MONTHS	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> EVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
New York		U.S.A.				PRINCE GEORGES MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Clinton		Southern Maryland Hospital Center		Secretary		Religious--							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						Church Secretary							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		11301 Keytson Avenue (20735)			
Maryland		Prince George's		Clinton									
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
John A. Stadler						Mary C. Nead							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		None		118-16-8027		Carl P. Blomgren - Same As #13 A-E							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST													
DUE TO, OR AS A CONSEQUENCE OF (b) LEIOMYSARCOMA with metastasis.													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (c)													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). SEPTICEMIA, GANGRENE OF BOWEL, HYPERTENSION.													
19a. DATE OF OPERATION Sept, 1984		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED LEIOMYSARCOMA		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/14</u> , 19 <u>84</u> to <u>9/13</u> , 19 <u>84</u> , that (I) (we) lost sow the deceased alive on <u>7/13</u> , 19 <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Gurbux H. Nachnani</i>						DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/14/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gurbux H. Nachnani M.D.						22e. ADDRESS 9015 Woodyard Road Clinton, Maryland 20735							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 9/17/84		23c. NAME OF CEMETERY OR CREMATORIUM Maryland Veterans Cemetery		23d. LOCATION CITY OR TOWN Cheltenham, Maryland		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME Lee Funeral Home Inc.		ADDRESS 6633 Old Alexander Ferry Road Clinton, Md.		25a. DATE REC'D. BY REGISTRAR SEP 20 1984		25b. REGISTRAR'S SIGNATURE <i>Jane Dawson</i>							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON IN 5TH FLOOR, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2 5 4 4 5							
1 - STATE REGISTRAR																			
I. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE			LAST				2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH	DAY	YEAR	2b. HOUR		
DANIEL JEROME BOTELER												<input checked="" type="checkbox"/>		9	07	1984	M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED <i>DEA</i>		MONTH	DAY	YEAR	2d. HOUR		
Male	White	March 27, 1965			19 yrs.			MONTHS	DAYS	HOURS	MIN.	9		07	1984	M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/>		NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		7c. BALTIMORE CITY OR COUNTY OF DEATH			
WASHINGTON, D.C.		U.S.A.														PRINCE GEORGE			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Clinton		Southern Maryland Hospital Center										Gas Station Attendant, PVT							
13a. STATE MARYLAND		13b. COUNTY Prince George		13c. CITY OR TOWN Clinton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10507 THRIFT RD.		20735								
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST								
WILLIAM		JAMES		BOTELER			PATRICIA		A.		PURDY								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE GRADE OR RATES)		16c. INFORMANT MR. William J. Boteler, same as #13		ADDRESS													
NO		* * * * *		212-96-0099															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
8161 IMMEDIATE CAUSE (a) <i>Transsections of the torso.</i> DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?							
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR 3:42 P.M. 9 07 1984			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) passenger on motorcycle out of control, thrown off into electric pole guide wire														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street			21f. LOCATION STREET 10500 block Brandywine Rd.			CITY OR TOWN Brandywine, Pr.			COUNTY Geo.		STATE Md.						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) M.D. Deputy										DATE SIGNED 9/7/1984							
EXAMINER'S NAME (TYPE OR PRINT)		MEDICAL EXAMINER																	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 5009 Rayburn Ct., Temple Hills, Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE BURIAL Sept. 10, 1984			23c. NAME OF CEMETERY OR CREMATORIAL RESURRECTION CEMETERY,			23d. LOCATION CITY OR TOWN CLINTON, P.G., MARYLAND		23e. COUNTY CLINTON		23f. STATE MD							
24. FUNERAL DIRECTOR NAME LEE FUNERAL HOME, 6633 Old Alexander ADDRESS Ferry Road, Clinton, Maryland 20735		25a. DATE REC'D. BY REGISTRAR SEP 14 1984										25b. REGISTRAR'S SIGNATURE <i>Landell</i>							
BP _____																			
DHMH - 17 (VR A15 ME (5))																			
20M 4/82																			

2000-2001

2000-2001

2000-2001

2000-2001

2000-2001

2000-2001

2000-2001

2000-2001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pool 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25446											
										REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR									
Edward A. Brick						Sept. 12, 1984						6:55 P.M.									
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS									
Male			White		Dec 6, 1913		MONTH DAY YEAR			70	YRS.	MONTHS	DAYS	HOURS	MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Washington DC			USA				PRINCE GEORGES MD.			Statistician				US Gov't							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			12c. ADDRESS										
CLINTON			SOUTHERN MD HOSPITAL		YES <input type="checkbox"/> NO <input type="checkbox"/>			2912 Upland Ave. 20747			Same as #13										
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST										
George					Brick	Ellen					Murphy										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
Yes			579-05-4544		Eudora L. Brick			CARDIOPULMONARY ARREST													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) CONGESTIVE HEART FAILURE			(c) CORONARY ARTERY DISEASE															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/12/84 to 9/12/84, that (I) (we) last saw the deceased alive on 9/12/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE <i>G. Nachmani M.D.</i>		22c. DEGREE			22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Nachmani M.D.			22e. ADDRESS 9015 Woodlawn Rd. CLINTON, MD.			22f. DATE SIGNED 12/13/84							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			CITY OR TOWN		COUNTY		STATE						
Burial			15 Sept 84		Resurrection Cemetery			Clinton PG													
24. FUNERAL DIRECTOR NAME			Robert E. Wilhelm		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE										
					Suitland, Md.			SEP 18 1984			<i>Julia Davidson-Pendleton</i>										

A



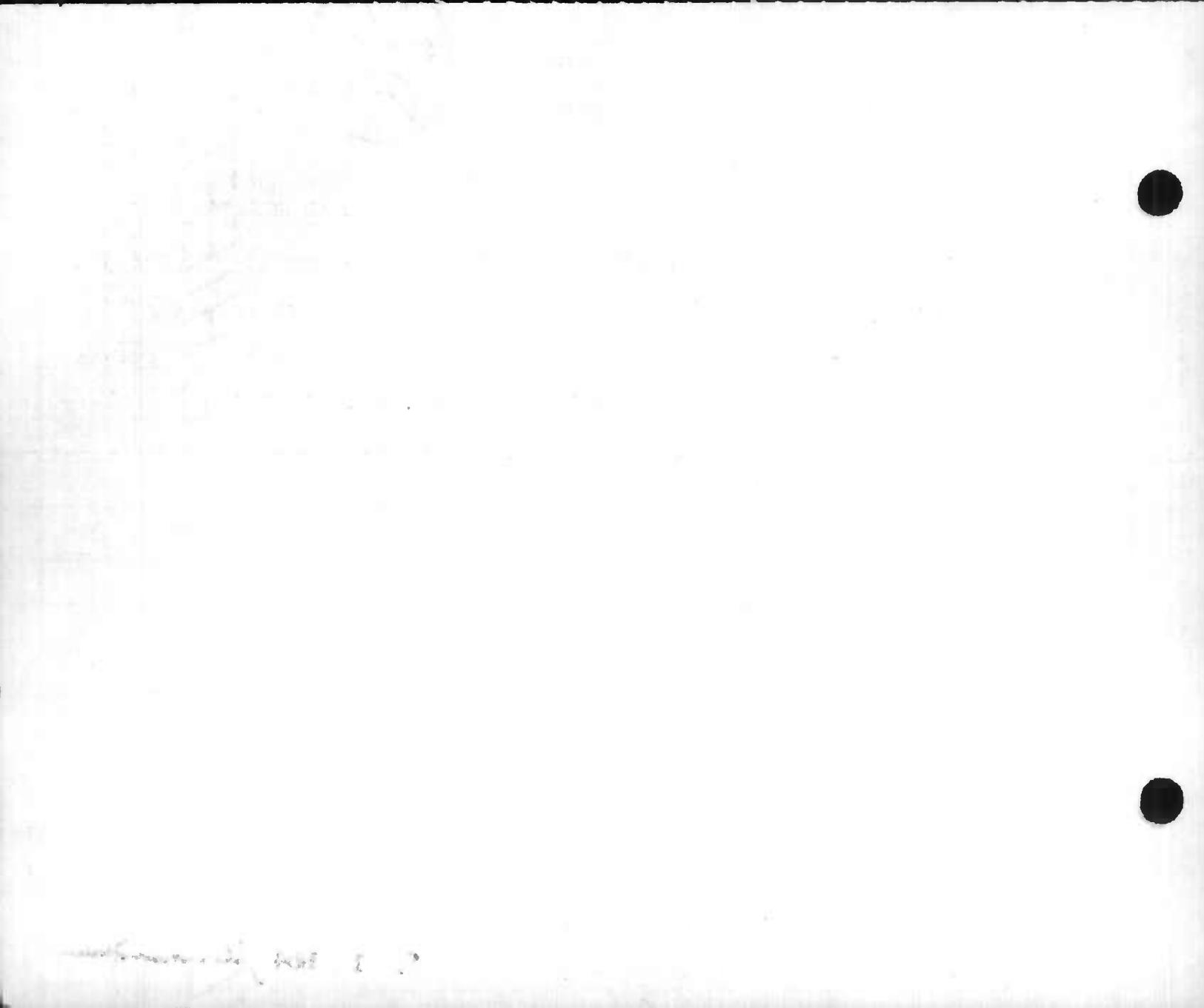
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						25447					
						REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH MONTH DAY YEAR	2b. HOUR				
ELLA					BRIGGS	09-08-84	8:50AM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female		Black		Sept. 15. 1900		83					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.					
Paxville. S.C.		USA									
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
		PRINCE GEORGE'S GENERAL HOSP				Housewife			Private		
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Glenarden		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1525-7th Street 20769			
14. FATHER'S NAME Joseph		MIDDLE Ludd		LAST		15. MOTHER'S MAIDEN NAME Liza		MIDDLE Ludd		LAST Briggs	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 247 22 5250		17. INFORMANT Willie Briggs		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		ADDRESS 1525-7th St Glenarden		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-24, 1984, to 9/8, 1984, that (I) (we) lost sow the deceased alive on above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>N.B. Vellanki</i>		DEGREE MD.		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9-10-1984					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N.B. VELLANKI		22e. ADDRESS 11294 Mc Cheverly, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/15/1984		23c. NAME OF CEMETERY OR CREMATORIAL Harmony Memorial		23d. LOCATION CITY OR TOWN Landover P.G. Md.		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME R.N. Horton Co.		ADDRESS 600-Kennedy St. N.W. D.C.		25a. DATE REC'D. BY REGISTRAR SEP 17 1984		25b. REGISTRAR'S SIGNATURE <i>Maureen Pendleton</i>					



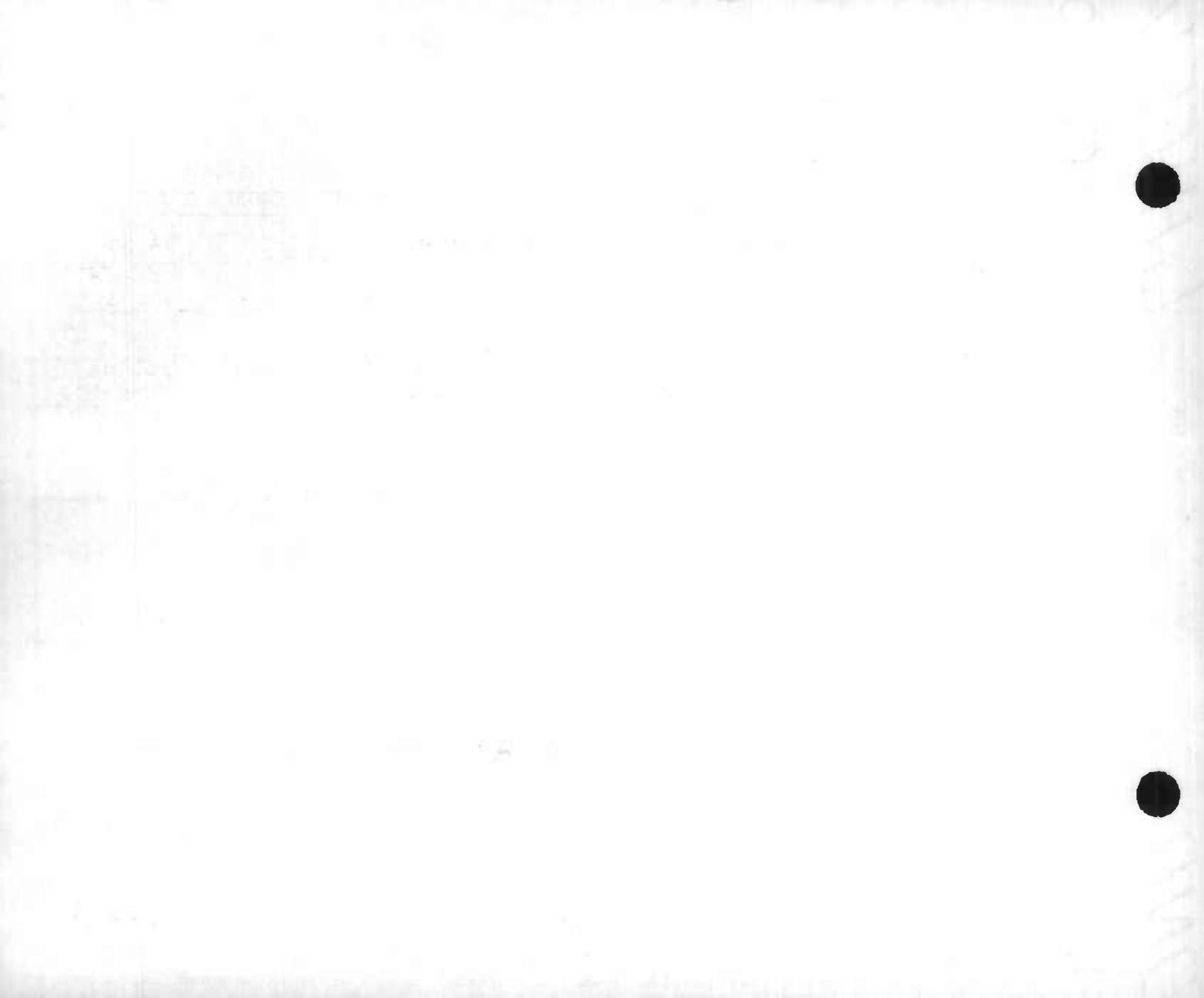
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 25448					
1. DECEASED NAME (TYPE OR PRINT) <b>DELORES McLean BROOKS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>09-30-84</b>		2b. HOUR <b>9:55PM M</b>						
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 23, '35</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>49</b>		IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY</b>					
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGE'S GENERAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Oxon Hill</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1515 Southview Terrace (20745)</b>			
14. FATHER'S NAME FIRST <b>John Lacy</b>		MIDDLE <b>Mc Lean</b>		LAST		15. MOTHER'S MAIDEN NAME FIRST <b>Iola Mc Lean</b>		MIDDLE		LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>n/a</b>		17. INFORMANT <b>Bunn Level, North Carolina</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of Biliary Tree, Sepsis.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cancer of Biliary System, Reg. ful.</i>		DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>9138</b> CITY OR TOWN <b>9130</b> COUNTY <b>1984</b> STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>9/30 1984</b> , to <b>9/30 1984</b> , that (I) (we) last saw the deceased alive on <b>9/30 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Dennis F. Frank</i>		22c. DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <b>10/1/84</b>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dennis F. Frank</i>		22f. ADDRESS <b>1 Neop. Drive Cheverly, MD</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6th Oct. 84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>McLean Chapel Cem.</b>		23d. LOCATION CITY OR TOWN <b>Bunn Level</b>		23e. COUNTY <b>N. Carolina</b>			
24. FUNERAL DIRECTOR <b>3831 Ga. Avenue N. W. Wash. D. C.</b> Latney & Daffard Funeral Home						25a. DATE REC'D. BY REGISTRAR <b>OCT 9 1984</b>		25b. REGISTRAR'S SIGNATURE <i>J. Latney &amp; Daffard Funeral Home</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be retained for use by the burial/transit period. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25449					
												REG. NO.					
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			9.23.1984									12.10 PM		
ELLEN R. BRYERTON																	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female			Caucasian			February 22, 1897			87			MONTHS		DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.					
Illinois			United States						Prince George's County								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Riverdale			Leland Memorial Hospital									Operator			Beauty Shop		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			MD.		
Maryland			Montgomery			Gaithersburg						16404 Montecrest Lane			20878		
14. FATHER'S NAME			MIDDLE LAST			15. MOTHER'S MAIDEN NAME											
John			J. Costello			Hanna									Shanahan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No			N/A 388-20-1498			(Niece) Jo Ellen Domalski			16404 Montecrest Gaithersburg, MD 20878								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
DO TO, OR AS A CONSEQUENCE OF (b)												CARDO PULMONARY ARREST					
DO TO, OR AS A CONSEQUENCE OF (c)												RENAL FAILURE					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I COMMA OF undetermined cause (d)												HYPER TENSION					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 9/20 19 84 to 9/23 19 84, that (I) (we) last saw the deceased alive on 9/23 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.												ADRI					
22b. SIGNATURE			DEGREE									22c. DATE SIGNED					
ASIF. S. ADRI			MRBS									ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		9.23.84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									22f. ADDRESS					
ASIF. S. ADRI			4713-BERWYN Road, COLLEGE PARK														
23a. BURIAL, CREMATION, REMOVAL (1) Burial			23b. DATE 1984			23c. NAME OF CEMETERY OR CREMATORIAL All Saints Cemetery			23d. LOCATION DesPlaines Cook Co. Illinois								
September 27																	
24. FUNERAL DIRECTOR NAME P.A. 7557 Wisconsin Ave, Bethesda, Maryland			25a. DATE REC'D. BY REGISTRAR SEP 26 1984									25b. REGISTRAR'S SIGNATURE Julia Davidson Mandell					



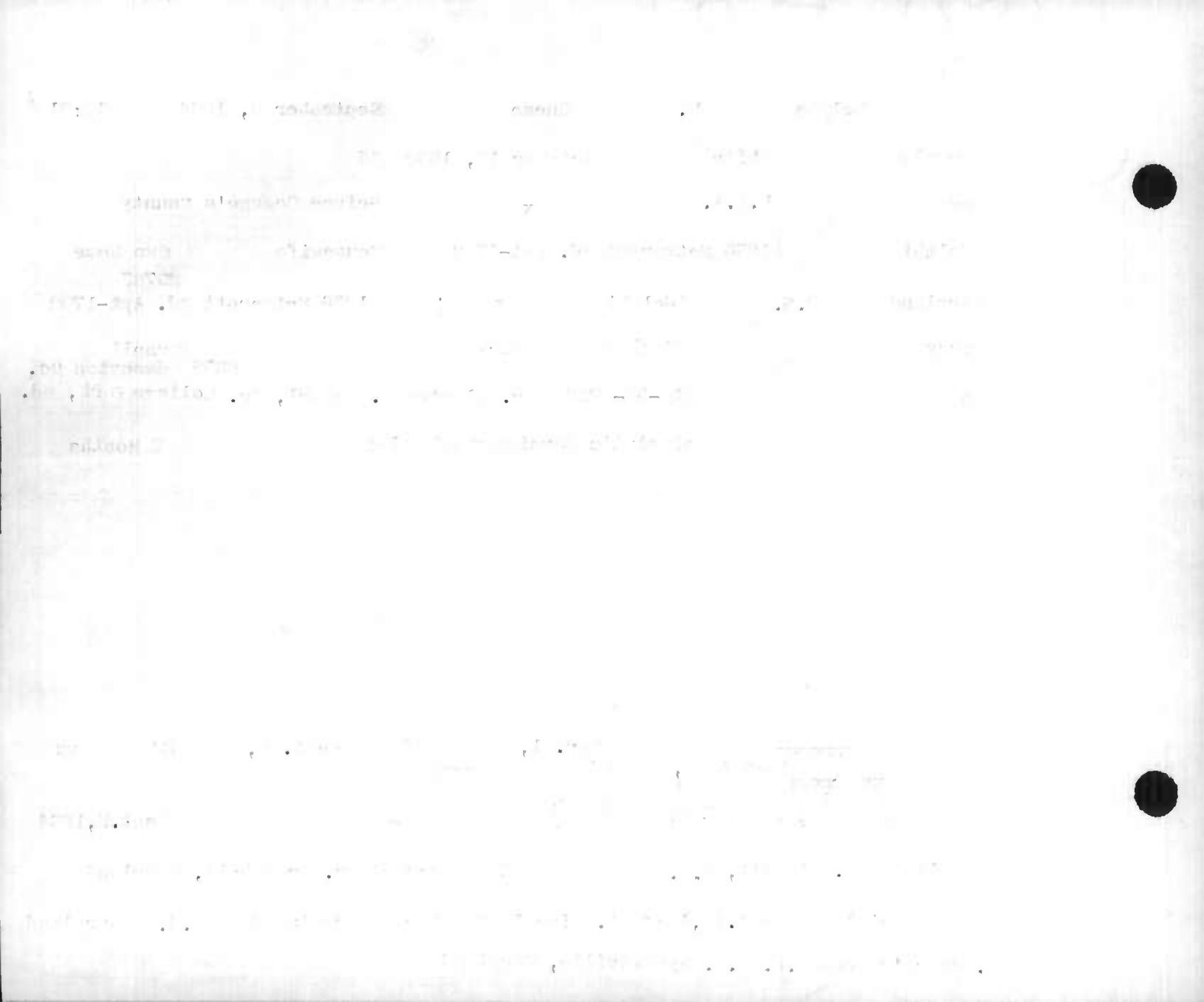
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, or by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 25450			
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>Delpha</b>	MIDDLE <b>M.</b>	LAST <b>Buese</b>			September 9, 1984			12:01 A		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
<b>Female</b>			<b>White</b>			<b>October 12, 1898</b>			<b>85</b>			YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Iowa</b>			7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County</b>			IF UNDER 24 HRS	
10 CITY OR TOWN OF DEATH <b>Adelphi</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1836 Metzerott Rd. Apt-1702</b>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>				
13a STATE <b>Maryland</b>			13b COUNTY <b>P.G.</b>			13c CITY OR TOWN <b>Adelphi</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>20783 1836 Metzerott Rd. Apt-1702</b>	
14. FATHER'S NAME FIRST <b>Harry</b>			MIDDLE <b></b>	LAST <b>Taylor</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b>			MIDDLE <b></b>	LAST <b>Yarnell</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-38-2726</b>			17. INFORMANT			ADDRESS <b>8608 Edmonston Rd. Dr. Clayton S. McCarl, Sr. College Park, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Colon</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 Months</b>			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <b>Nov. 1, 1983</b> to <b>Sept. 9, 1984</b> , that (I) <input checked="" type="checkbox"/> lost soul the deceased alive on <b>August 24, 1984</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did <input type="checkbox"/> view the body after death.													
22b. SIGNATURE <b>W.S. Wimsatt MD</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22c. DATE SIGNED <b>Sept. 9, 1984</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>William A. Wimsatt, M.D.</b>			22e ADDRESS <b>8150 Lakecrest Dr. Greenbelt, Maryland</b>										
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b DATE <b>Sept. 12, 1984</b>			23c NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln Cemetery</b>			23d LOCATION CITY OR TOWN <b>Brentwood</b> COUNTY <b>P.G.</b> STATE <b>Maryland</b>				
24 FUNERAL DIRECTOR NAME <b>F. Gasch's Sons F.H. P.A. Hyattsville, Maryland</b>										25 DATE RECEIVED BY REGISTRAR <b>SEP 11 1984</b> 25b. REGISTRAR'S SIGNATURE <b>Julie Davidson-Pender</b>			



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

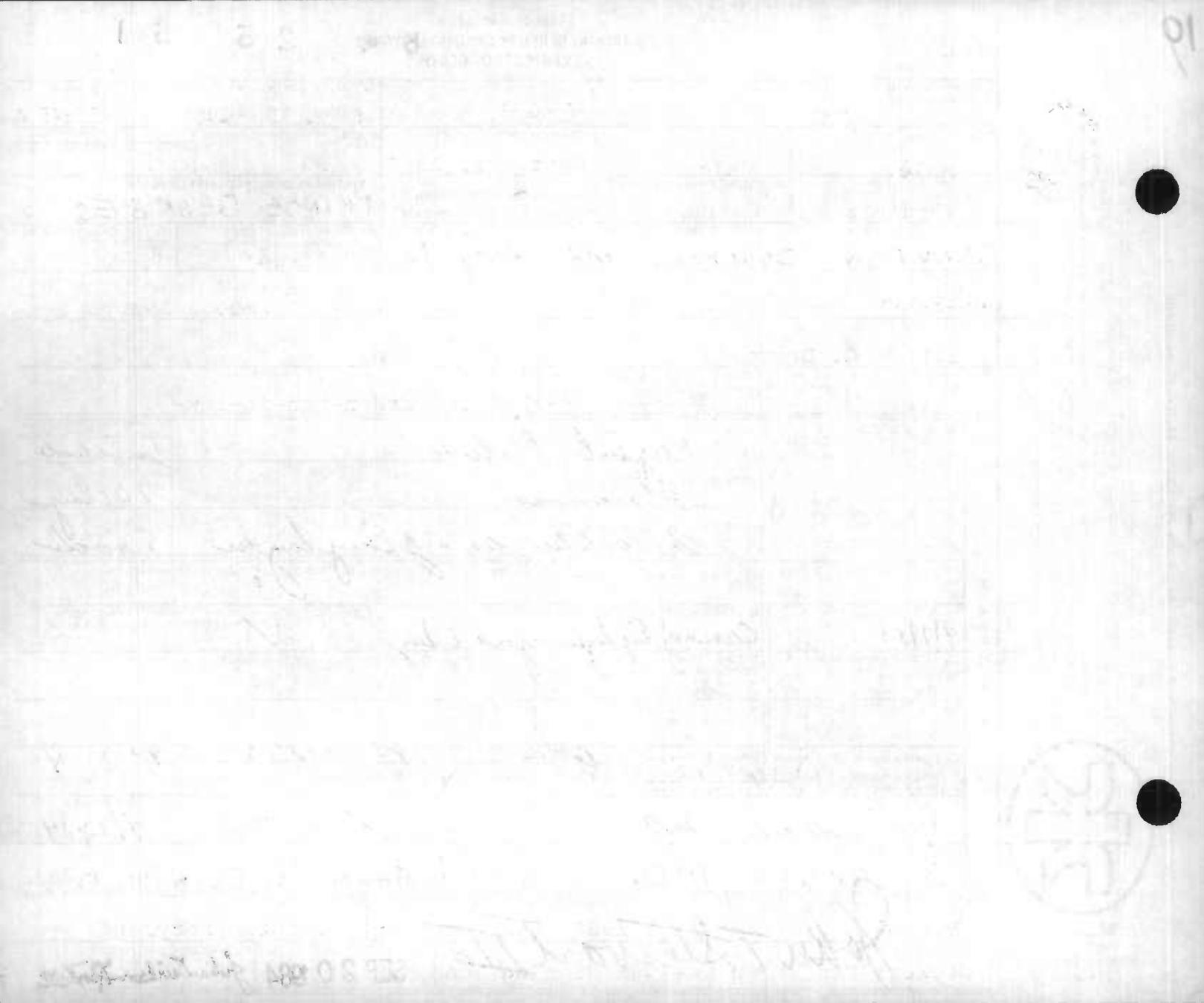
**1 - STATE  
REGISTRATION**

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

2 51 45 1

REG. NO.

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2d. HOUR		
JOHN			BURRELL			SEPT. 13 1984			12:45 A			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS, LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		Black		Sept. 25, 1924			59 yrs.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		USA					PRINCE GEORGES MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
CLINTON		Southern Md Hospital					Retired			20144		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE Maryland		13b. COUNTY Fort Washington		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 7711 Denmeade Avenue		
14. FATHER'S NAME FIRST MIDDLE LAST												
Edward G. Burrell		15. MOTHER'S MAIDEN NAME Mable Kinney										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS					
yes		225 20 7239		Walter Parson-son-in-law-								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia</i>												
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Malignant Cancer of Esophagus</i>												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>One week</i> <i>10 days</i> <i>5 months</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <i>Cancer Esophagus and lung</i>												
19a. DATE OF OPERATION 9/17/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cancer Esophagus and lung</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>APRIL 19, 84</i> to <i>Sept 13, 1984</i> , that (I) (we) lost saw the deceased alive on <i>Sept 12, 1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>J P Caruso M.D.</i>		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>9/13/84</i>				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J CARUSO, M.D.</i>		22f. ADDRESS <i>9131 Piscataway Rd., CLINTON, MD.</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept 15, 1984		23c. NAME OF CEMETERY OR CREMATORIAL Resurrection			23d. LOCATION CITY OR TOWN Clinton, Maryland			COUNTY		
24. FUNERAL DIRECTOR NAME <i>John Stewart</i>		25a. DATE REC'D. BY REGISTRAR SEP 20 1984			25b. REGISTRAR'S SIGNATURE <i>Julie Johnson</i>							
Stewart Funeral Home-4001 Benning Road, N.E.												



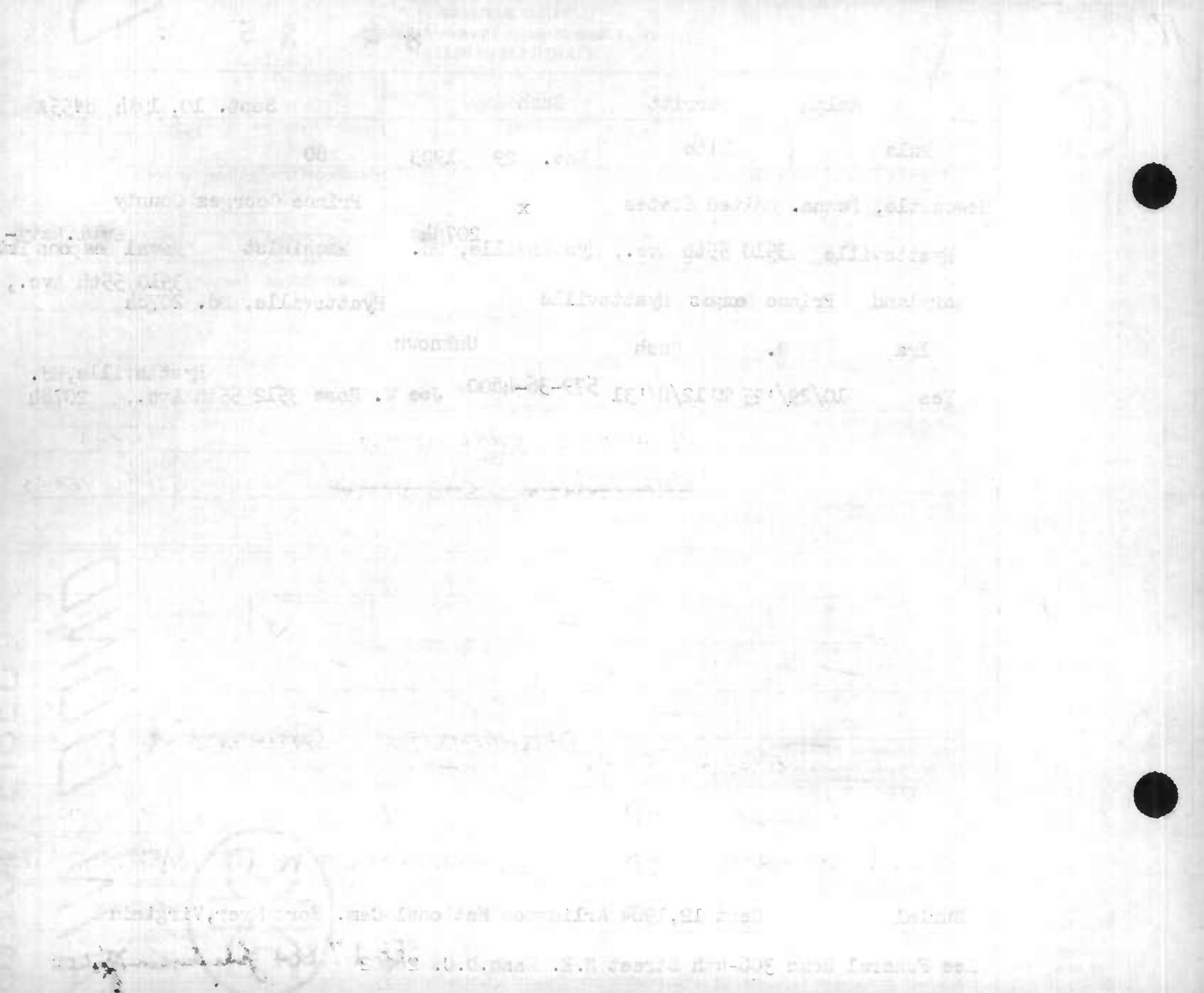
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

25452

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>Ralph</b>	MIDDLE <b>Merritt</b>	LAST <b>Bush</b>	2a. DATE OF DEATH <b>Sept. 10, 1984</b>	MONTH YEAR	2b. HOUR <b>8:55 AM</b>			
3. SEX <b>Male</b>			4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Nov.</b> DAY <b>29</b> YEAR <b>1903</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Newcastle, Penna.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges County MD.</b>					
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3510 55th Ave., Hyattsville, Md.</b>		20784	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machinist</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Navy-Naval Weapons Bd</b>				
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Hyattsville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>3510 55th Ave., Hyattsville, Md. 20784</b>				
14. FATHER'S NAME FIRST <b>Ira</b>			MIDDLE <b>G.</b>	LAST <b>Bush</b>	15. MOTHER'S MAIDEN NAME FIRST Unknown		MIDDLE LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. 10/29/1925 TO 12/8/1931		16c. WAR OR DATE(S) 579-36-4800	17. INFORMANT Joe W. Rose	ADDRESS <b>Hyattsville, Md. 20784</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) <b>BRONCHIOGENIC CARCINOMA</b>				1 1/2 YEARS				
			(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH P.M. DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) SEPTEMBER 5 1984		21f. LOCATION STREET	CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) this physician attended the deceased from saw the deceased alive on SEPTEMBER 5 1984, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) did not view the body after death.											
22b. SIGNATURE <i>Dennis J. Hand</i>			22c. DEGREE <i>MD</i>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22e. DATE SIGNED <i>9/10/84</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DENNIS J. HAND M.D.</b>			22e. ADDRESS <b>4600 CONNECTICUT AVE NW, WASHINGTON DC</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Sept 12, 1984</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Fort Myer, Virginia</b>	COUNTY	STATE		
24. FUNERAL DIRECTOR NAME <b>Lee Funeral Home</b>			ADDRESS <b>300-4th Street N.E. Wash.D.C.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 17 1984</b>	25b. REGISTRAR'S SIGNATURE <i>Jane Davidson Pendall</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

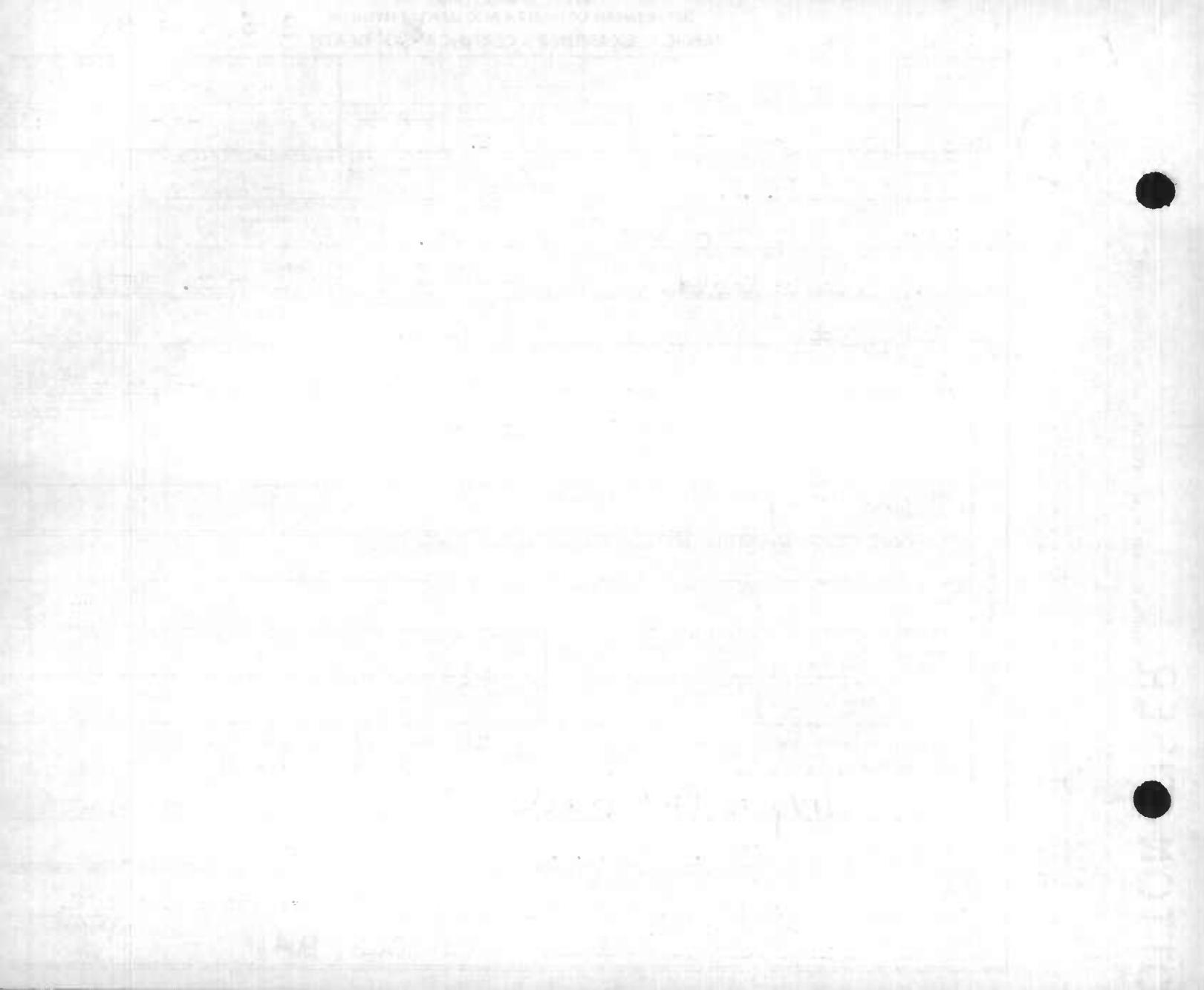
25453

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Jeanette	MIDDLE Coutu	LAST Cahill	2a DATE OF DEATH September 23, 1984	MONTH September	DAY 23	YEAR 1984	2b HOUR 11:25a
3. SEX Female			4. RACE White		5. DATE OF BIRTH MONTH 7 DAY 9 YEAR 23	6. AGE, IN YEARS (LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN 0		
7a. BIRTHPLACE COUNTRY Massachusetts			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.				
10. CITY OR TOWN OF DEATH Camp Springs			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Telephone Operatpr P.G. Hosp.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland			13b. COUNTY P.G.	13c. CITY OR TOWN Landover	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7607 Muncy Road 20785				
14. FATHER'S NAME FIRST Philodolph			MIDDLE 	LAST Coutu	15. MOTHER'S MAIDEN NAME FIRST Cecile	MIDDLE 	LAST Chapagne			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 032-12-0173		17. INFORMANT Paul F. Cahill (Husband)		ADDRESS Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> due to hypokalemia/renal failure						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 hrs				
DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPTIC SHOCK</u>						96 hrs				
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Postop - re lysis of adhesions/hemorrhage for partial small bowel obstruction</u>						96 hrs				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Cirrhosis of the liver</u>										
19a. DATE OF OPERATION 30 August 84			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Partial Small bowel obstruction, Incisional Hernia			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>21 AUGUST 1984</u> to <u>3 SEPTEMBER 1984</u> , that (1) (we) last saw the deceased alive on <u>3 SEPTEMBER 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>James S. Nevill</u>			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 9/3/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James S. Nevill L. Westfall			22e. ADDRESS USAF Hosp, Andrews AFB, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/7/84	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National			23d. LOCATION CITY OR TOWN Ft. Myer			
24. FUNERAL DIRECTOR Francis Casch's Sons Funeral Home P.A.			4739 Baltimore Ave. Hyattsville, Md. 20781			25a. DATE REC'D. BY REGISTRAR SEP 10 1984			25b. REGISTRAR'S SIGNATURE John K. Parker	



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												2 5 4 5 4	REG. NO.						
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)						LAST			2a. DATE OF DEATH ESTIMATED	MONTH	DAY	YEAR	2b. HOUR			
			TRAVIS WADE			CAPPETTA			9-26-84			19							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR 24 HOUR M			
Male		White		March 31, 1984		YRS.		5 27				9-26-84		9-26-84		19 3:32P M			
7a. BIRTHPLACE [STATE OR FOREIGN COUNTRY]		7b. CITIZEN OF WHAT COUNTRY?										8		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		Prince George's County	
Maryland		U.S.A.																	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION [TYPE OF WORK FOR MOST OF WORKING LIFE]		12b. KIND OF BUSINESS OR INDUSTRY					
Clinton		Southern Maryland General Hosp.										N/A		N/A					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland		Prince Georges		Upper Marlboro		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8919 Simeon Ct. 20772											
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST									
Nicholas Cappetta						Wende J. Naefe													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
N/A		N/A		N/A		Mr & Mrs. Nicholas Cappetta		Same as #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) <u>Sudden infant death syndrome</u> DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause</u> lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF																			
(c) _____																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET															
22a. I certify that I took charge of the remains described above, held an death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												and in my opinion							
ACTUAL SIGNATURE		<u>Margarita Korell</u> M.D. Assistant										TITLE (SPECIFY) MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, M.D.										DATE SIGNED 9-27-84							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE									
Burial		9/28/84		Resurrection Cemetery		Clinton		Prince Georges Md.											
24 FUNERAL DIRECTOR NAME		Lee Funeral Home Inc.		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
						20752 1984		Gina Mandell											
DHMH - 17 (VR A15 ME (5))																			
20M 4/82																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please return carbon copies, Pages 1 and 2 which bear the State Seal of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner will be notified.

## MEDICAL CERTIFICATION

1 - STATE REGISTRAR			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						2 5 4 5 5 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR				
Anthony John CAPPUCIO						September 7, 1984			10:40p.m.				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
Male		White		March 15 1912		72			MONTHS DAYS				
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS				
New York		USA				Prince George's County			MONTHS DAYS HOURS MIN.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Lanham		Doctors' Hosp. of Prince Geo. Co.						Shoe Cutter (Ret)			MD.		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Maryland		Pr. Georges		College Park					9014 Rhode Island Ave., 20740				
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME						(LAST)			
Frank				Gaetana						(unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE NAME OR DATES)			17. INFORMANT			ADDRESS				
N/A			N/A 098-09-4390A			Rose Cappuccio-wife-(same as 13e)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1Wk	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) END STAGE												DUE TO, OR AS A CONSEQUENCE OF	
{ (c) CHRONIC												DUE TO, OR AS A CONSEQUENCE OF	
{ RESPIRATORY PROBLEMS 50 yrs												COPD + HEART FAILURE 1 yr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES MELLITUS													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8-7-84, 19_____, to 9-7-84, 19_____, that (I) (we) last saw the deceased alive on 9-7-84, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE					DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					9-8-84			
A-C. VATA					9326 Larkwood-Raven Rd., unknown								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-10-1984			23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cemetery			23d. LOCATION CITY OR TOWN Silver Spring		COUNTY STATE Montgomery Md.			
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home					11800 N.H. Ave. Silver Spring, Md.			25a. DATE REC'D. BY REGISTRAR SEP 10 1984		25b. REGISTRAR'S SIGNATURE June Dawson-Hendell			

6/27/73

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*Released by Dr. Kaufman*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be attached to the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

25456

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
<i>William M CAVE</i>						09 12 84						4:02 AM					
3. SEX			4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS				
MALE			WHITE	April 10, 1904			84 80			MONTHLY DAYS			HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
VIRGINIA			U.S.A.						PRINCE GEORGE								
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
CLINTON			Southern Md. Hospital			FARMER, CARPENTER, P.G. Board Of Ed.											
USUAL RESIDENCE IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION			13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE		
			MARYLAND			PRINCEGEORGE			UpperMarlboro			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			7010 Woodyard Rd. 20772		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST						
			DAVID		CAVE				DOLLY		LICHLITER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
NO			N/A			578-24-4812			Wife Anna M. Cave, same as #13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY			IMMEDIATE CAUSE (a)			Septic Shock									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
															Hours		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)			Septic											
			(c)			DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from saw the deceased alive on <i>9/12/84</i> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did not view the body after death.																	
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS									<i>9/12/84</i>		
<i>L. KAUFMAN M.D.</i>						10905 Ft. Wash. Rd. Ft. Wash., Md.											
23a. BURIAL, CREMATION, REMOVAL SPECIES			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY			STATE		
BURIAL			Sept. 14, 1984			Resurrection Cemetery, Clinton, Maryland											
24. FUNERAL DIRECTOR NAME			LEE FUNERAL HOME, 6633 Old Alexander Ferry Rd. Clinton, Maryland 20735			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
									SFP 14 1984								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-trust permit. Then please attach carbon copies, pages 1 and 2 should be filed within 7 days of each other with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25457			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Margaret Mae CAVILEER						September 1, 1984						5:45 AM	
3. SEX <b>Female</b>			4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>August 15 1907</b>			6. AGE (IN YEARS LAST BIRTHDAY) 77			IF UNDER 1 YEAR MONTHS DAYS YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b>			MD.	
10. CITY OR TOWN OF DEATH <b>Lanham</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Doctor's Hospital of P. G. Co.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>				
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>College Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>20740 9101 Autoville Drive</b>				
14. FATHER'S NAME FIRST <b>Charles</b>			MIDDLE <b>H.</b>	LAST <b>Riddle</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b>			MIDDLE <b>C.</b>	LAST <b>Gates</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>215-09-1344B</b>			17. INFORMANT ADDRESS <b>Rte. 1 Box 4, Thomas Betty L. Wilson, Daughter Ct. Indian Head, Md</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia and Hypotension</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <b>Urinary tract Infection</b> (c) <b>Small Bowel Infection</b>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVING IN PART 1a. <b>Hemolytic Anemia, organic Brain syndrome</b>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>8-31 1984</b> to <b>9-1 1984</b> , that (I) (we) last saw the deceased alive on <b>9-1 1984</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>R. Arora</b>			22c. DEGREE <b>M.D.</b>			22d. ATTENDING PHYSICIAN <b>X</b> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <b>8/9/84</b>				
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. Arora, M.D.</b>			22g. ADDRESS <b>14300 Gallant Fox Lane, Bowie, Maryland</b>										
23a. BURIAL, CREMATION, REMOVAL SPECIES <b>Burial</b>			23b. DATE <b>9-4-1984</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Brentwood</b>			COUNTY <b>Pr. Geo.</b>	STATE <b>Md.</b>
24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons, P.A. Hyattsville, Maryland</b>			25a. DATE REC'D. BY REGISTRAR <b>SEP 6 1984</b>			25b. REGISTRAR'S SIGNATURE <b>John Davidson Pendleton</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpaper. Pages 1 and 2 should be filed within 24 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at 301-731-7070.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 25456	
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>EDITH</i>	MIDDLE <i>Mamie</i>	LAST <i>CLARY</i>	2a. DATE OF DEATH MONTH JUNE DAY 10, 1984			YEAR 9 9 84	2b. HOUR 3 <sup>22</sup> AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH June DAY 10, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>North Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>PRINCE GEORGE Co. MD.</i>							
10. CITY OR TOWN OF DEATH <i>Riverdale</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Leland Memorial Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Waitress</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Food Service</i>						
13a. STATE <i>Maryland</i>		13b. COUNTY <i>P.G. Co.</i>		13c. CITY OR TOWN <i>Mt. Rainier</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <i>3705 33rd Street / 20032</i>				
14. FATHER'S NAME FIRST <i>Unknown</i>		MIDDLE <i></i>		LAST <i></i>		15. MOTHER'S MAIDEN NAME FIRST <i>Nora</i>			MIDDLE <i>S.</i>		LAST <i>Powell</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT <i>Jack Clary (Son) 3705 33rd St. Mt. Rainier, Md.</i>			ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>IMMEDIATE</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>RESPIRATORY FAILURE</i>												2 MONTHS	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASPIRATION PNEUMONIA</i>												2 MONTHS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
ACUTE RENAL FAILURE, BASAL GANGLIONIC DISORDER													
19a. DATE OF OPERATION <i>6-12-84</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>SEVERE DEGENERATIVE ARTHRITIS - HIP REPLACEMENT</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>6-11</i> , 19 <i>84</i> , to <i>9-9</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>9-9</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Jerald A. Reinshagen</i>		22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>9/9/84</i>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JERALD A. REINSHAGEN</i>		22f. ADDRESS <i>4404 QUEENSBURY RD RIVERDALE, MD.</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Sept/13/84</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Floral Garden Cemetery</i>			23d. LOCATION CITY OR TOWN <i>High Point, Guilford Co., N.C.</i>						
24. FUNERAL DIRECTOR NAME <i>Chambers Funeral Home Riverdale, Maryland</i>		ADDRESS			25a. DATE REC'D. BY REGISTRAR <i>SEPT 13 1984</i>			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson Pendleton</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

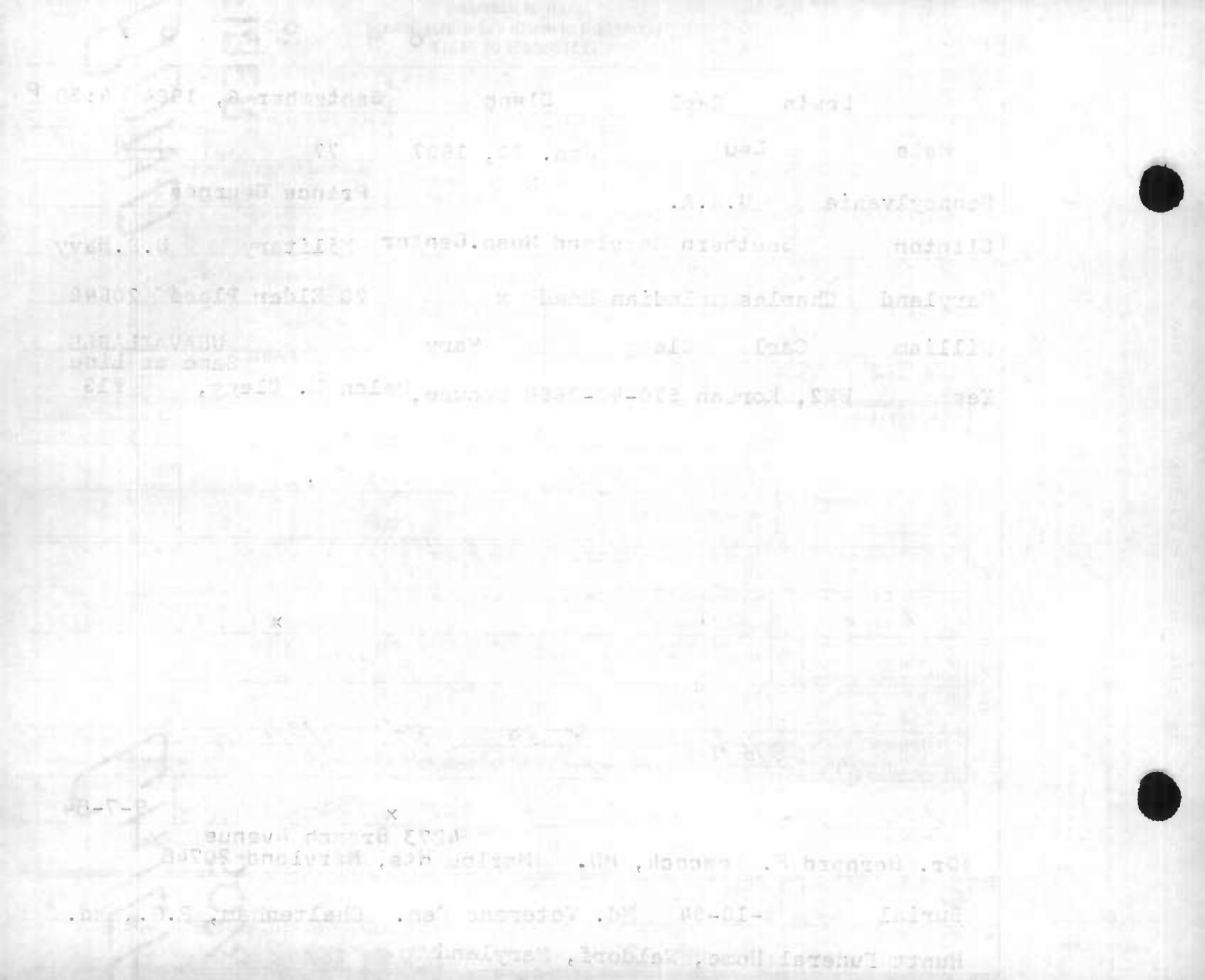
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or items 18 through 20 show any injury, an other traumatic event, the medical certification section must be completed.)

## MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH25459  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>Lewis</b>	MIDDLE <b>Carl</b>	LAST <b>Clegg</b>	2a. DATE OF DEATH <b>September 6, 1984</b>	MONTH DAY YEAR	2b. HOUR <b>4:30 P</b>	
3. SEX <b>Male</b>		4. RACE <b>Cau</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 30, 1907</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>77 yrs.</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		8. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b>		
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hosp. Center</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Military</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Indian Head</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>20 Elder Place 20640</b>	
14. FATHER'S NAME FIRST <b>William</b>		MIDDLE <b>Carl</b>	LAST <b>Clegg</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b>			UNAVAILABLE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW2, Korean 570-40-3690</b>			17. INFORMANT <b>Spouse, Helen E. Clegg,</b>		ADDRESS <b>Same as Line #13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hepatic Cirrhosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2) <b>8-30 1984 to 9/6/84 1984</b>				
21d. INJURY OCCURRED <b>AT HOME</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET <b>4273 Branch Avenue</b>		CITY OR TOWN <b>Marlow Hts, Maryland 20748</b>	COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>8-30 1984 to 9/6/84 1984</b> , that (I) (we) last saw the deceased alive on <b>9/6/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									22c. DATE SIGNED <b>9-7-84</b>
22b. SIGNATURE <b>Bernard F. Peacock, MD.</b>		22d. DEGREE <b>MD.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Bernard F. Peacock, MD.</b>		22f. ADDRESS <b>4273 Branch Avenue</b>			22g. DATE REC'D. BY REGISTRAR <b>SEP. 11 1984</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-10-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veterans Cem.</b>		23d. LOCATION CITY OR TOWN <b>Cheltenham, P.G., Md.</b>		COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Huntt Funeral Home, Waldorf, Maryland</b>		ADDRESS			25a. DATE REC'D. BY REGISTRAR <b>SEP. 11 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Judith Deirdre Broderick</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

### MEDICAL CERTIFICATION

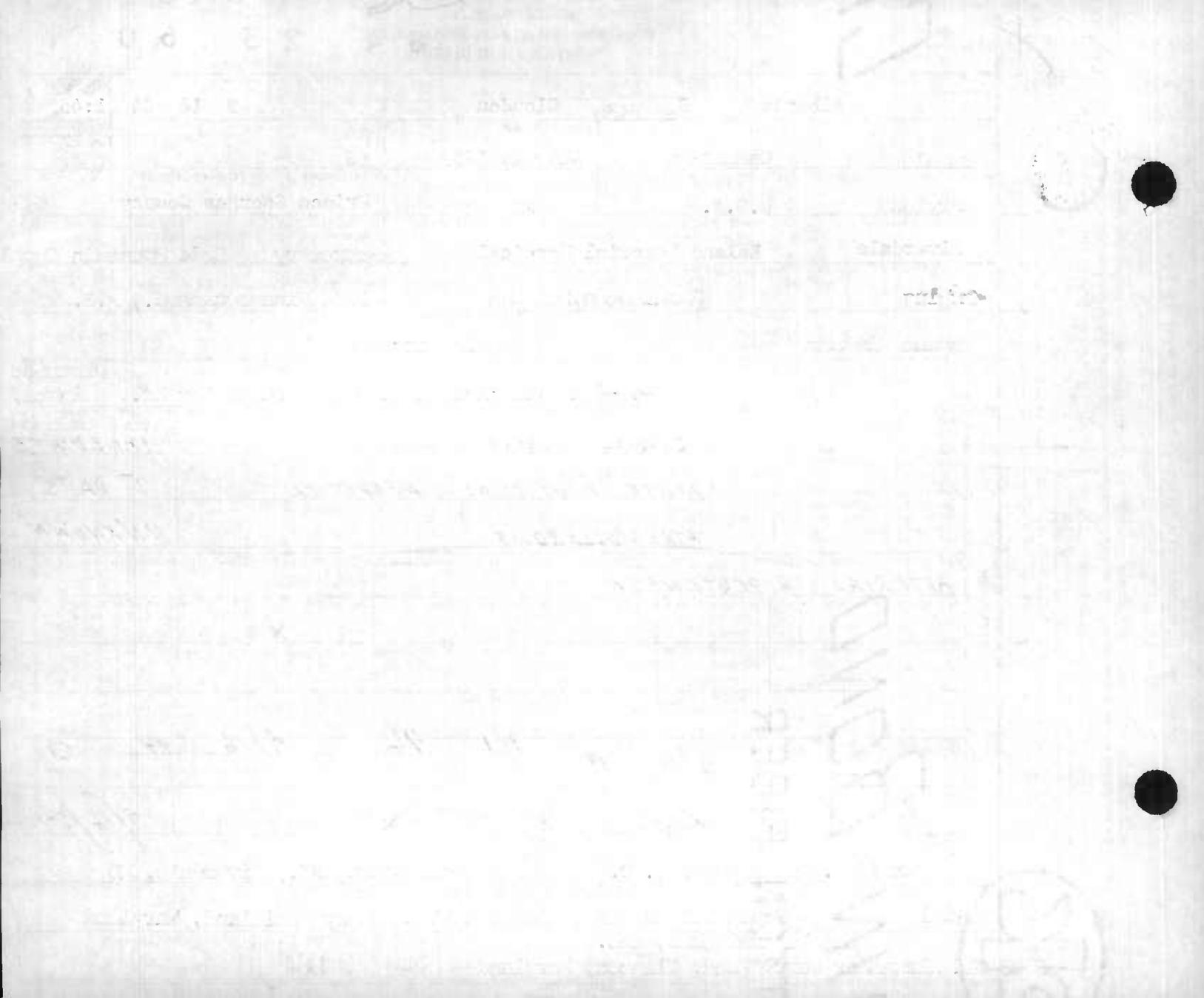
1 - FOR  
STATE  
REGISTRAR

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

2 5 4 6 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>Alberta</b>	MIDDLE <b>Beatrice</b>	LAST <b>Clouden</b>	2a DATE OF DEATH MONTH <b>September</b>	DAY <b>18</b>	YEAR <b>1984</b>	2b HOUR <b>1:45 A.M.</b>
3. SEX <b>Female</b>			4 RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH <b>July</b>		DAY <b>2</b>	YEAR <b>1899</b>	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS <b>85</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges County MD</b>			
10 CITY OR TOWN OF DEATH <b>Riverdale</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Leland Memorial Hospital</b>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Soda Fountain Suppl</b>	
13a. STATE <b>DC</b>			13b. COUNTY <b>Washington, DC</b>	13c. CITY OR TOWN <b>Washington, DC</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3364 Minnesota Ave., N.E. 20999</b>	
14. FATHER'S NAME FIRST <b>Eugene</b>			MIDDLE <b>Windsor</b>	LAST	15 MOTHER'S MAIDEN NAME FIRST <b>Fannie</b>		MIDDLE	LAST <b>Ferguson</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17 INFORMANT <b>Lillian Stack - 2200 Scott Key Dr., Heights,</b>		ADDRESS <b>District</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE MYOCARDIAL INFARCTION</b>						5 DAYS
			DUE TO, OR AS A CONSEQUENCE OF (c) <b>ATHEROSCLEROSIS</b>						UNKNOWN
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>ARTERIAL HYPERTENSION</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9/16 1984</b> to <b>9/16 1984</b> , that (I) (we) did not view the body after death. saw the deceased alive on <b>9/16 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									22c. DATE SIGNED <b>9/16/84</b>
22b. SIGNATURE <i>Jerald A. Reinshagen</i>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jerald A. Reinshagen, M. D.</b>		22e. ADDRESS <b>4404 Queensberry Rd., Riverdale, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>September 18, 1984</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Suitland, Maryland</b>	23e. COUNTY <b>Maryland</b>	23f. STATE <b>MD</b>	
24. FUNERAL DIRECTOR NAME <b>Lee Funeral Home, Inc.</b>		ADDRESS <b>Old Alexander Ferry Road, Clinton, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 20 1984</b>		25b. REGISTRAR'S SIGNATURE <i>Le Davidson-Randall</i>			
DHMR - 16 50M 4/83 BP 999999 (VRA 15, 4) 6633									



20

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

25461

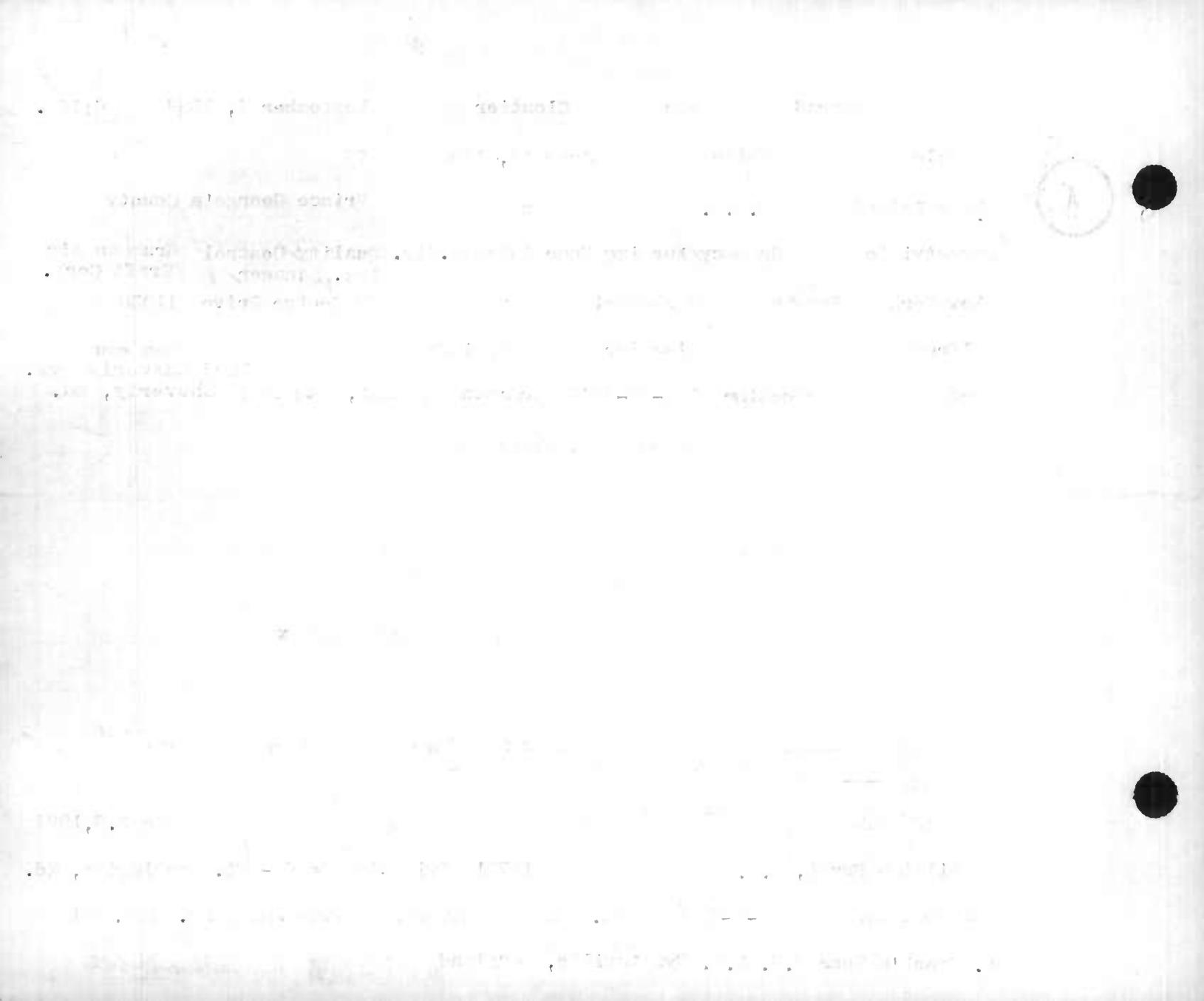
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>Conrad</b>	MIDDLE <b>Jean</b>	LAST <b>Cloutier</b>	2a DATE OF DEATH <b>September 4, 1984</b>	MONTH YEAR	2b HOUR <b>6:15P.M.</b>
3. SEX <b>Male</b>		4. RACE <b>White</b>		S. DATE OF BIRTH MONTH DAY YEAR <b>June 14, 1908</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>76</b>	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Rhode Island</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD.</b>		
10 CITY OR TOWN OF DEATH <b>Forestville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Regency Nursing Home &amp; Rehab.Ctr.</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Quality Control Ins. Manager</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Grumman Air Craft Corp.</b>	
13a STATE <b>New York</b>		13b COUNTY <b>Nassau</b>		13c CITY OR TOWN <b>Manhasset</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST <b>Alfred</b>		MIDDLE <b></b>	LAST <b>Cloutier</b>	15 MOTHER'S MAIDEN NAME FIRST <b>Celinda</b>		MIDDLE <b></b>	LAST <b>Rondeau</b>
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Peacetime 068-03-4543</b>		17 INFORMANT <b>Norman Mausolf, Stepson</b>		ADDRESS <b>3103 Cheverly Ave. Cheverly, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Liver Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f LOCATION STREET		CITY OR TOWN	COUNTY STATE
22a I certify that (I) <input type="checkbox"/> (his/her) attended the deceased from <b>6-26 1984</b> to <b>9-4 1984</b> , that (I) <input type="checkbox"/> (we) last saw the deceased alive on <b>8-31 1984</b> , and that in (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE <i>William Kent Furst M.D.</i>		DEGREE		22c. DATE SIGNED <b>Sept. 5, 1984</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William Furst, M.D.</b>		22e ADDRESS <b>11701 Livingston Road - Ft. Washington, Md.</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>9-6-1984</b>		23c NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln Crematory</b>		23d LOCATION CITY OR TOWN <b>Brentwood Pr. Geo. Md.</b>	
24 FUNERAL DIRECTOR NAME <b>F. Gasch's Sons F.H. P.A. Hyattsville, Maryland</b>				25a DATE REC'D. BY REGISTRAR <b>SEP 10 1984</b>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pendell</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other tragicomic event, the medical examiner must be notified.

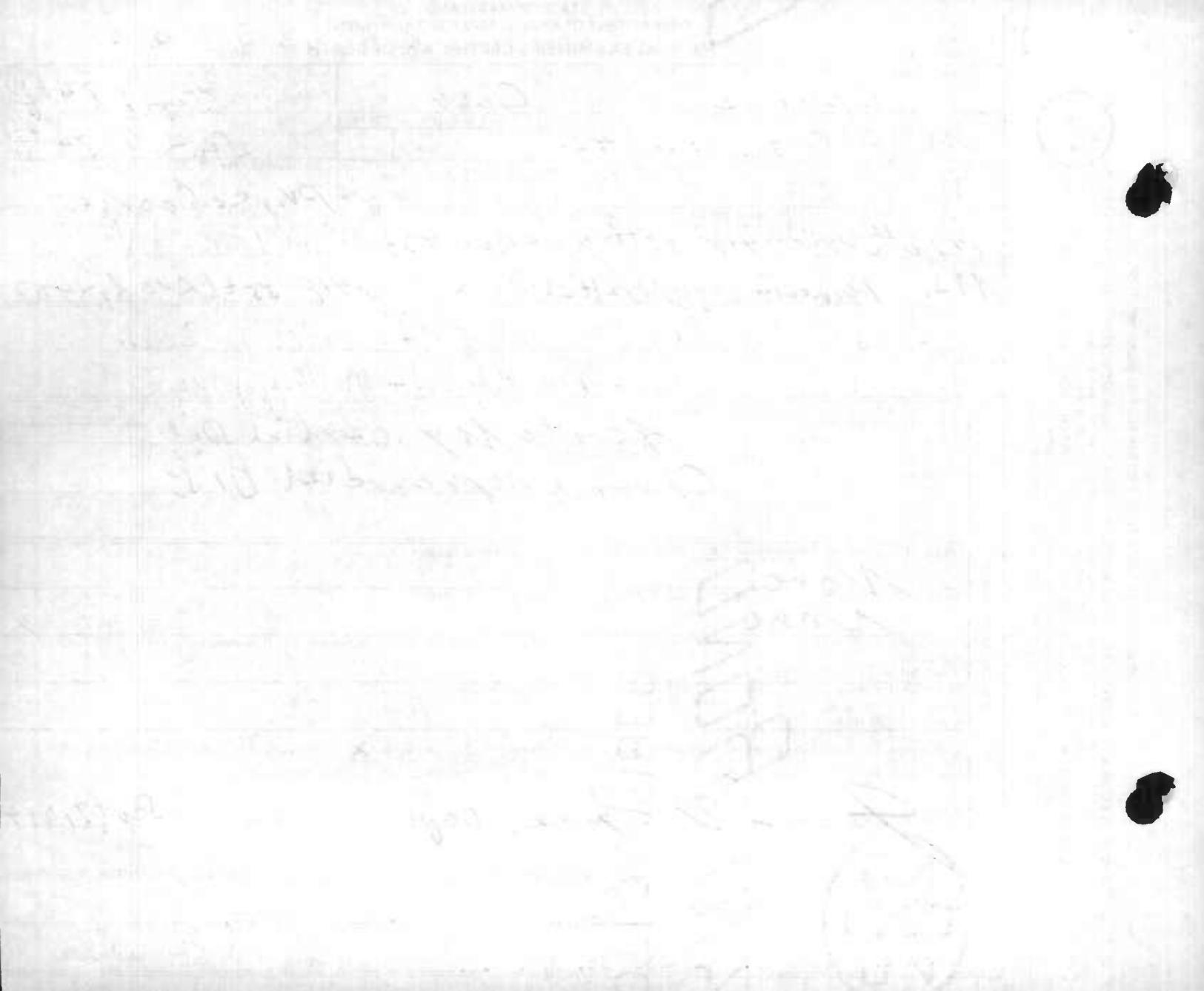
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 2. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												25462				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED				MONTH	DAY	YEAR	2b. HOUR M		
<i>Levone</i>						<i>Cobb</i>	<i>Sept. 6 1984</i>				19	00	PM	84600		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS (LAST BIRTHDAY) TRRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD			
<i>m</i>		<i>blk</i>		<i>Jan 26 42</i>			<i>42</i>						<i>Sept. 3 1984</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED WIDOWED				9. BALTIMORE CITY OR COUNTY OF DEATH				
<i>Ala.</i>				<i>US</i>				<i>Married</i>				<i>Prince George's</i>				
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY				
<i>Huntington</i>				<i>3418 55th Ave Apt. 403</i>				<i>SANITARY ENGR</i>				<i>MD</i>				
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS				
<i>MD</i>				<i>Prince George's</i>		<i>Huntington</i>		<i>Yes</i>				<i>3418 55th Ave Apt 403</i>				
14. FATHER'S NAME				MIDDLE		LAST		15. MOTHER'S MAIDEN NAME								
<i>John</i>				<i>Hall</i>		<i>Ella</i>		<i>M. Cobb</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<i>Yes</i>				<i>232-70-5636</i>				<i>Mrs. Ella M. Hall / Mother</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial D.S.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																
(b) <i>Chronic myocardial D.S.</i> DUE TO, OR AS A CONSEQUENCE OF																
(c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																
19a. DATE OF OPERATION <i>None</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE <i>John T. Rhines</i> M.D. D.C.P. MEDICAL EXAMINER												TITLE (SPECIFY)				
EXAMINER'S NAME (TYPE OR PRINT)												ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE 9-13-84				23c. NAME OF CEMETERY OR CREMATORIAL Harmony Memorial Pk.				23d. LOCATION CITY OR TOWN Landover		COUNTY	STATE	
BP																
24. FUNERAL DIRECTOR NAME John T. Rhines Co., 3015 12th St. N.E., D.C.												25a. DATE REC'D. BY REGISTRAR Sep 13 1984		25b. REGISTRAR'S SIGNATURE <i>Richard Pendle</i>		
DHMH - 17 (VR A15 ME (5)) 20M 4/82																



**GO HOSPITAL OR ATTENDING PHYSICIAN.** The  
retained by the hospital or attending physician.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

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of lotus



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death.

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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25464				
										REG. NO.				
1 - STATE REGISTRAR			2a. DATE OF DEATH							2b. HOUR				
1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			MONTH	DAY	YEAR	11 15 A.M.			
CELESTE			M.		COLLINS			9	12	84				
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
FEMALE			CAUC.		MONTH	DAY	YEAR	55			MONTHS	DAYS	IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8			YRS.			9. BALTIMORE CITY OR COUNTY OF DEATH			
Conn.			USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>						PRINCE GEORGES			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
CLINTON			SOUTHERN MARYLAND HOSPITAL CENTER							Accountant			Accounting	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13e. STREET ADDRESS / ZIP CODE						
Maryland			Pr. George		Camp Springs			6400 Gifford Lane 20748						
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
Joseph					DeFelice	Josephine					Langella			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS						
no			046-22-7711		Cynthia M. Collins same as item 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										2-3 HRS.				
DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of the ovary										6 mos				
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)							21f. LOCATION STREET		21f. LOCATION CITY OR TOWN	21f. LOCATION COUNTY	21f. LOCATION STATE
22a. I certify that (I) (this hospital) attended the deceased from 9/12 1984 to 9/12 1984, that (I) (we) last saw the deceased alive on 9/12 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 8/12/84				
22b. SIGNATURE <i>Chas F. Calvo MD</i>			22d. DEGREE							22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Charles F. Calvo MD			22g. ADDRESS 3710 Revere St - Prince Hills, MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23d. LOCATION COUNTY	23d. LOCATION STATE			
Burial			9/14/84		Resurrection Cemetery			Clinton		P.G.	Md.			
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR							25b. REGISTRAR'S SIGNATURE				
G.P. KALAS 6160 Oxon Hill Rd. Oxon Hill, Md.			SEP 14 1984							<i>Lia Davidson-Randall</i>				

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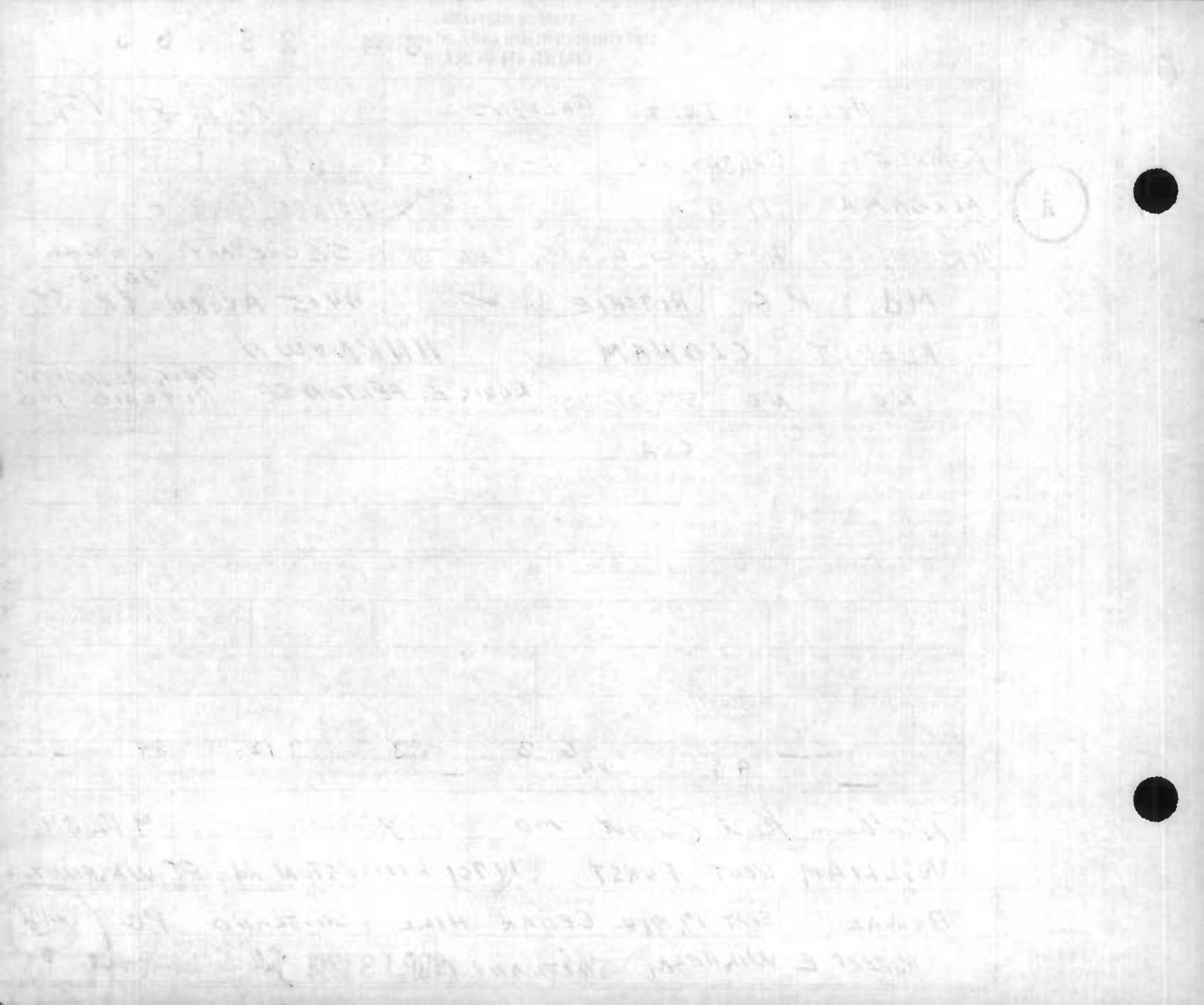
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 25465			
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 9 - 12 - 84							2b. HOUR 155 P.M.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>HILDA</b>	MIDDLE <b>INEZ</b>	LAST <b>COLLINS</b>								
3. SEX <b>FEMALE</b>			4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 - 18 - 15</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ALABAMA</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		B MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE George's</b> MD.					
10. CITY OR TOWN OF DEATH <b>FORT WASH.</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FORT WASH. REHAB. CENTER</b>							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SECRETARY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>LEGAL</b>	
13a. STATE <b>Md.</b>			13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>RITCHIE</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>9405 ACORN PK ST 20743</b>			
14. FATHER'S NAME FIRST <b>ALBERT</b>			MIDDLE <b>OLONAM</b>	LAST	15. MOTHER'S MAIDEN NAME FIRST <b>UNKNOWN</b>			MIDDLE	LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>577-28-4003</b>		17. INFORMANT <b>LOUIS E. FELTON SR.</b>			ADDRESS <b>9405 ACORN PK RITCHIE MD.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CVA</b>													
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>6 - 3 - 1983</b> to <b>9 - 12 - 1984</b> , that (I) (we) last saw the deceased alive on <b>9 - 6 - 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) (did not) view the body after death.													
22b. SIGNATURE <b>William Kent Furst MD</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>9-12-84</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WILLIAM KENT FURST</b>			22e. ADDRESS <b>11701 LIVINGSTON Rd FT. WASHINGTON</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>SEPT. 17, 1984</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>CEDAR HILL</b>			23d. LOCATION CITY OR TOWN <b>SUITLAND P.G. Md.</b>				
24. FUNERAL DIRECTOR NAME <b>ROBERT E. WILHELM</b>			ADDRESS <b>SUITLAND ABPT 18 1984</b>			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JULIA DAVIDSON-PENDLE</b>							



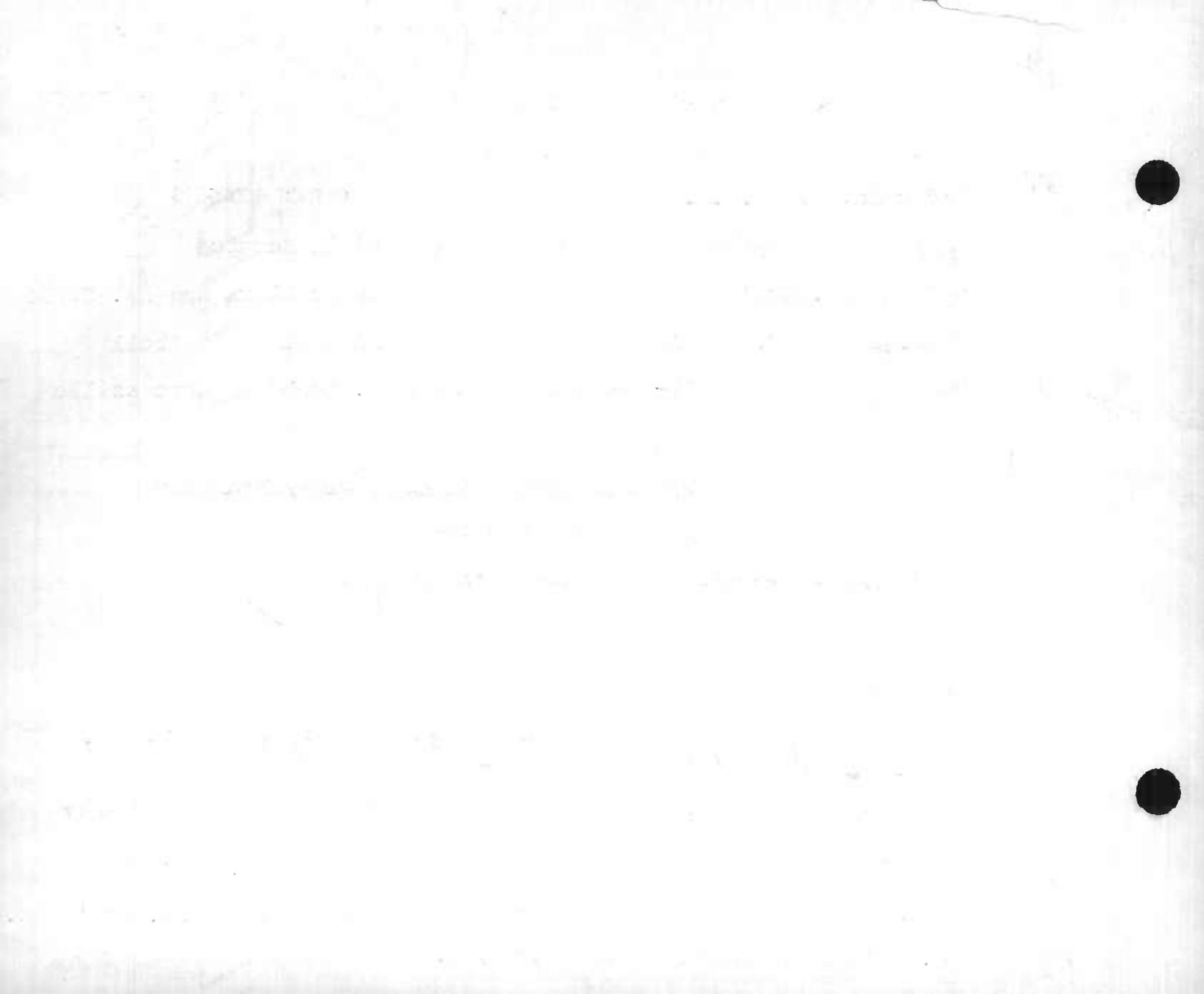
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IMPORTANT: If Item 21 is marked or Item 28 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										2 5 4 6 5			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
GEORGE Edward COMBS						09-09-84			3 30PM				
3. SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS (LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		Nov. 29, 1917			66 yrs			MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
California, Md.		U.S.A.					PRINCE GEORGE'S						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR (INDUSTRY)						
CHEVERLY		PRINCE GEORGE'S GENERAL HOSPITAL		Civil Service									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
Maryland		St. Mary's		Great Mills		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Chancellors Run Rd. 20634					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
George		E.		Combs		Lucy Elizabeth Abell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		217-18-5384A		Catherine E. Combs		Cardio-vascular Arrest							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b) Valvular Heart Disease, Coronary Artery disease				DUE TO, OR AS A CONSEQUENCE OF (c) Rheumatic Fever							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b) Valvular Heart Disease, Coronary Artery disease				DUE TO, OR AS A CONSEQUENCE OF (c) Rheumatic Fever							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (the physician) attended the deceased from show the deceased alive on 9/19/84, and that in (we) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (I) did not view the body after death.				1981 to 9/9/84									
22b. SIGNATURE <i>S. Polak MD</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/10/84							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Polak</i>		22e. ADDRESS 4700 Ruth Place Camp Springs											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-12-84		23c. NAME OF CEMETERY OR CREMATORIAL Holy Face Cemetery		23d. LOCATION CITY OR TOWN Great Mills		COUNTY St. Mary's Md.					
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley		ADDRESS Leonardtown, Md.		25a. DATE REC'D. BY REGISTRAR SEP 13 1984		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pandalee</i>							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR OUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2 5 4 6 7
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR
John			Steven	Conner, Jr.	<input checked="" type="checkbox"/>	9	6	19	84			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN			
Male	White	Jan. 17, 1984	7	6								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		2c. DATE PRONOUNCED DEAD			
Maryland		U.S.A.			<input type="checkbox"/>		<input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH		NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Lanham		Doctor's Hospital					N/A			N/A		
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Glenn Dale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10025 Worrell Ave. 20769				
14. FATHER'S NAME FIRST John		MIDDLE Steven		LAST Connor, Sr.		15. MOTHER'S MAIDEN NAME FIRST Susan		MIDDLE D.			LAST Jenkins	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. No		16c. ADDRESS N/A		17. INFORMANT Mrs. Ruth G. Jenkins		ADDRESS Address Same as No# 13e.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			<input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY AT HOME STREET, FACTORY, FARM, ETC.			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22b. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE Dennis F. Smyth, M.D. Assistant MEDICAL EXAMINER												
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn St. Balto., MD.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial Sept. 10, 1984		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood		23e. COUNTY P.G.		STATE Maryland		
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A.		ADDRESS Hyattsville, Maryland		25a. DATE REC'D. BY REGISTRAR SEP 10 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson Pendle						
20M 4/22												
DHMH - 17 (VR A15 ME (5))												

2000-01 Mexico 2001

initials  
in great shape  
all in  
several  
years

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reprinted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certifier must be present at the time of death.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25468					
										REG. NO.					
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			Sepatehember 29, 1984							8:45A M		
LOUISE ALTAMESE CRAYTON															
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Female			Black			Sept 18, 1933			51			MONTHS DAYS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. BALTIMORE CITY OR COUNTY OF DEATH			PRINCE GEORGE'S MD.			
Florida			U.S.A.						Prince George's						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY						
Lanham			Doctors' Hospital of Prince George's County			Housewife			none						
USUAL RESIDENCE IF NURSING HOME OR OTHER INSTITUTION (GIVE RESIDENCE BEFORE ADMISSION)										13a STREET ADDRESS / ZIP CODE					
13a STATE Maryland			13b COUNTY P.G.			13c CITY, OR TOWN Capitol Hgts			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			6622 Ronald Road #T4 20745			
14. FATHER'S NAME FIRST Ruben			MIDDLE			LAST Green			15. MOTHER'S MAIDEN NAME FIRST unknown			MIDDLE		LAST	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO. (# YES, GIVE WAR OR DATES)			17. INFORMANT SON ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinofibromatous breast</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
no			253 24 0763			Norman Crayton			Bellevue, Nebras.			1 hour			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) <u>Hypovolemic shock, Septic</u>			(c) <u>Hypovolemic infection</u>						12 hrs.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>1984</u> , to <u>1984</u> , that (II) (we) last saw the deceased alive on <u>1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (II) (we) (did) (did not) view the body after death.															
22b SIGNATURE <u>DR. ANDRES LARA</u>										DEGREE					
22d PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f DATE SIGNED <u>9-29-84</u>						
Andres Lara			8320 W. 32nd Street, Chevy Chase, MD												
23a BURIAL, CREMATION, REMOVAL SPEC#)			23b DATE			23c. NAME OF CEMETERY OR CREMATORIALy			23d LOCATION CITY OR TOWN			CITY		STATE	
Burial			Oct. 5, 1984			Harmony Mem. Park			Landover			Maryland			
24 FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Hunt Funeral Home 2801 7th St. N.E. D.C.										Oct 4 1984		John Davidson - Kendall			
DHMH - 16 50M 4/B3 (VRA 15, 4)															

A

2008 1 record 2008-2009-2010

2011-12 2012 2013-2014  
2014-15 2015-2016

2016-17 2017-2018 2018-2019

2019-2020 2020-2021

2020-2021 2021-2022

2021-2022 2022-2023

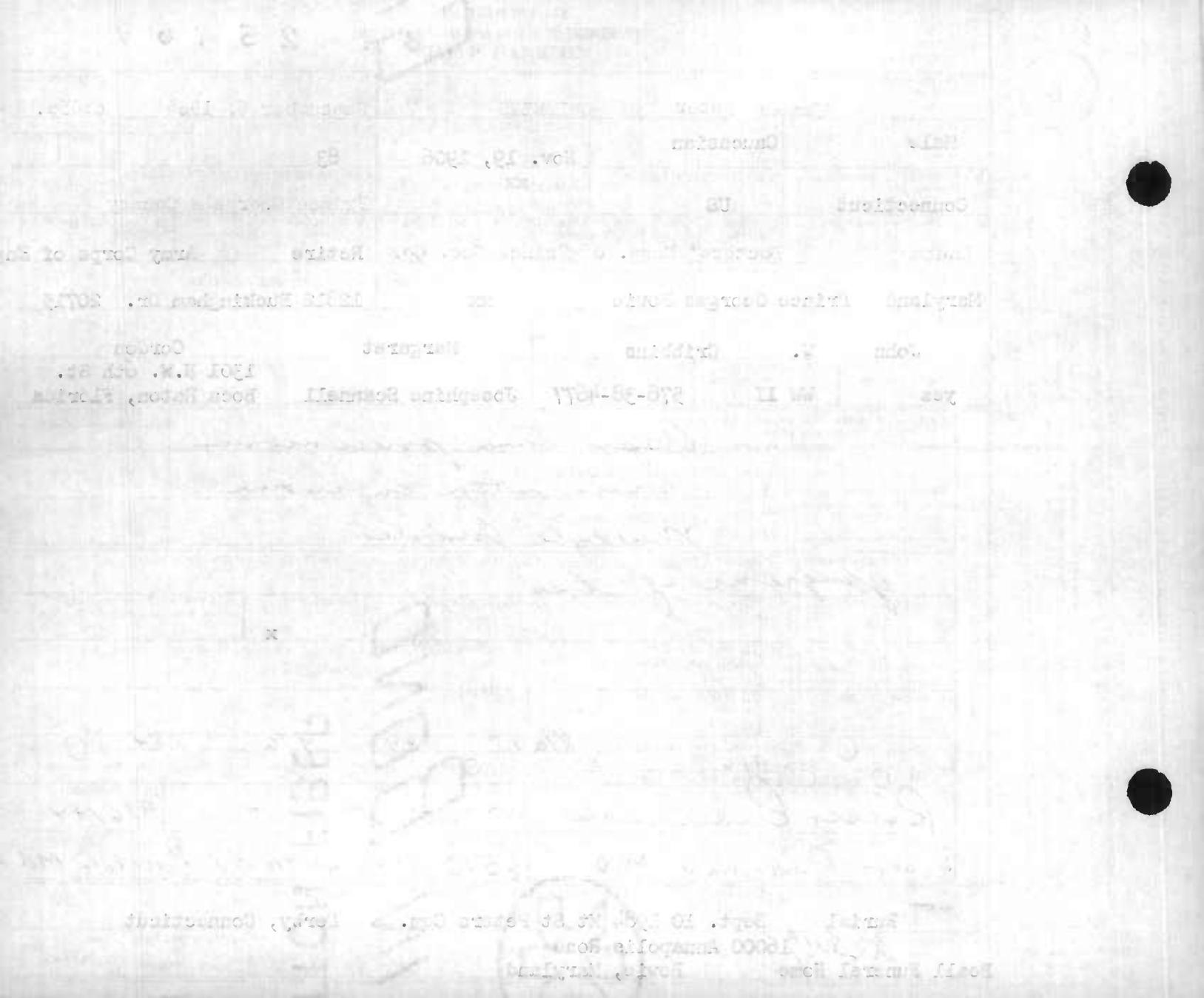
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 25469								
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR								
J. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 23 HRS HOURS MIN.						
Thomas Peter CRIBBINS						Nov. 19. 1906			83											
3. SEX Male			4. RACE Caucasian			7. CITIZEN OF WHAT COUNTRY? US			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County								
10. CITY OR TOWN OF DEATH Lanham			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hosp. of Prince Geo. Co.									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retire			12b. KIND OF BUSINESS OR INDUSTRY Army Corps of Eng					
13a. STATE Maryland			13b. COUNTY Prince Georges			13c. CITY OR TOWN Bowie			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 12812 Buckingham Dr. 20715								
14. FATHER'S NAME John W. Cribbins			15. MOTHER'S MAIDEN NAME Margaret Cordon									16. SOCIAL SECURITY NO. 578-38-4677			17. INFORMANT Josephine Scannell			ADDRESS 1301 N.W. 6th St. Boca Raton, Florida		
18. CAUSE OF DEATH (Enter only one cause per line for Part I, II, and III) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Brain stem infarction</i> (c) <i>Myocardial embolus</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>Gangrene of toes</i>																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that (I) (this hospital) attended the deceased from <i>8/20</i> , 19 <i>84</i> , to <i>9/6</i> , 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>9/6</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <i>9/6/84</i>								
22d. SIGNATURE <i>Robert Ruderman</i>			22e. DEGREE M.D.									ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert Ruderman M.D.</i>			22e. ADDRESS <i>6510 Kenilworth Av., Riverdale, Md.</i>																	
23a. BURIAL, CREMATION, REMOVAL (SPEC #)			23b. DATE <i>Burial Sept. 10 1984 Mt St Peters Cem.</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt St Peters Cem.</i>			23d. LOCATION CITY OR TOWN <i>Bowie, Maryland</i>			23e. COUNTY STATE								
24. FUNERAL DIRECTOR NAME <i>R. Beall</i>			24b. ADDRESS <i>16000 Annapolis Road</i>			24c. NAME OF CEMETERY OR CREMATORIAL <i>Bowie, Maryland</i>			25a. DATE REC'D. BY REGISTRAR <i>Sep 7 1984</i>			25b. REGISTRAR'S SIGNATURE <i>Edwardson Pendell</i>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be called.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						25470		
						REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Lula	B	Armstrong	CRICKENBERGER	September 25, 1984				8:15P M
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 21, 1896</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b>	7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>US</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b>	MD.				
10. CITY OR TOWN OF DEATH <b>Lanham</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Doctors' Hospital of Pr. Geo. Co.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>			
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Prince Georges</b>	13c. CITY OR TOWN <b>Hyattsville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>6700 Belcrest Rd. 20783</b>				
14. FATHER'S NAME FIRST <b>William</b>	MIDDLE	LAST <b>Armstrong</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Cora</b>	MIDDLE	LAST <b>Todd</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>224-42-4030A</b>	17. INFORMANT <b>Frances Lee Crickenberger</b>	ADDRESS <b>same as 13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u><i>Cardiopulmonary failure</i></u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>68 days</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u><i>Pneumonia, left with pleural effusion</i></u>								
DUE TO, OR AS A CONSEQUENCE OF (c) <u><i>Urinary Tract infection</i></u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <u><i>Debilitating illness with infection, uncontrolled Diabetes mellitus</i></u>								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>July 19, 1984</u> to <u>September 25, 1984</u> , that (I) (we) last saw the deceased alive on <u>September 25, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did / did not view the body after death.								
22b. SIGNATURE <u>Chin-Chuan Hsu</u>	22c. DEGREE <u>M.D.</u>	22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22e. DATE SIGNED <u>9/25/84</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Chin-Chuan Hsu M.D.</b>	22e. ADDRESS <b>6905 Baltimore Blvd., College Pk., Md. 20740</b>							
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>Removal burial</b>	23b. DATE <b>Sept 28 1984</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Augusta Memorial Park</b>	23d. LOCATION CITY OR TOWN <b>Staunton, Augusta Co., Virginia</b>	23e. COUNTY	23f. STATE			
24. FUNERAL DIRECTOR NAME <b>Beall Funeral Home</b>	24b. ADDRESS <b>16000 Annapolis Rd.</b>	25a. DATE REC'D. BY REGISTRAR <b>OCT 2 1984</b>	25b. REGISTRAR'S SIGNATURE <u>Jane Johnson Pendle</u>					

303.2.1A

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SECTION 1. The name of the corporation shall be "The Great Northern Telephone Company".

254-46-4030 - Please see the Classified section

Digitized by srujanika@gmail.com

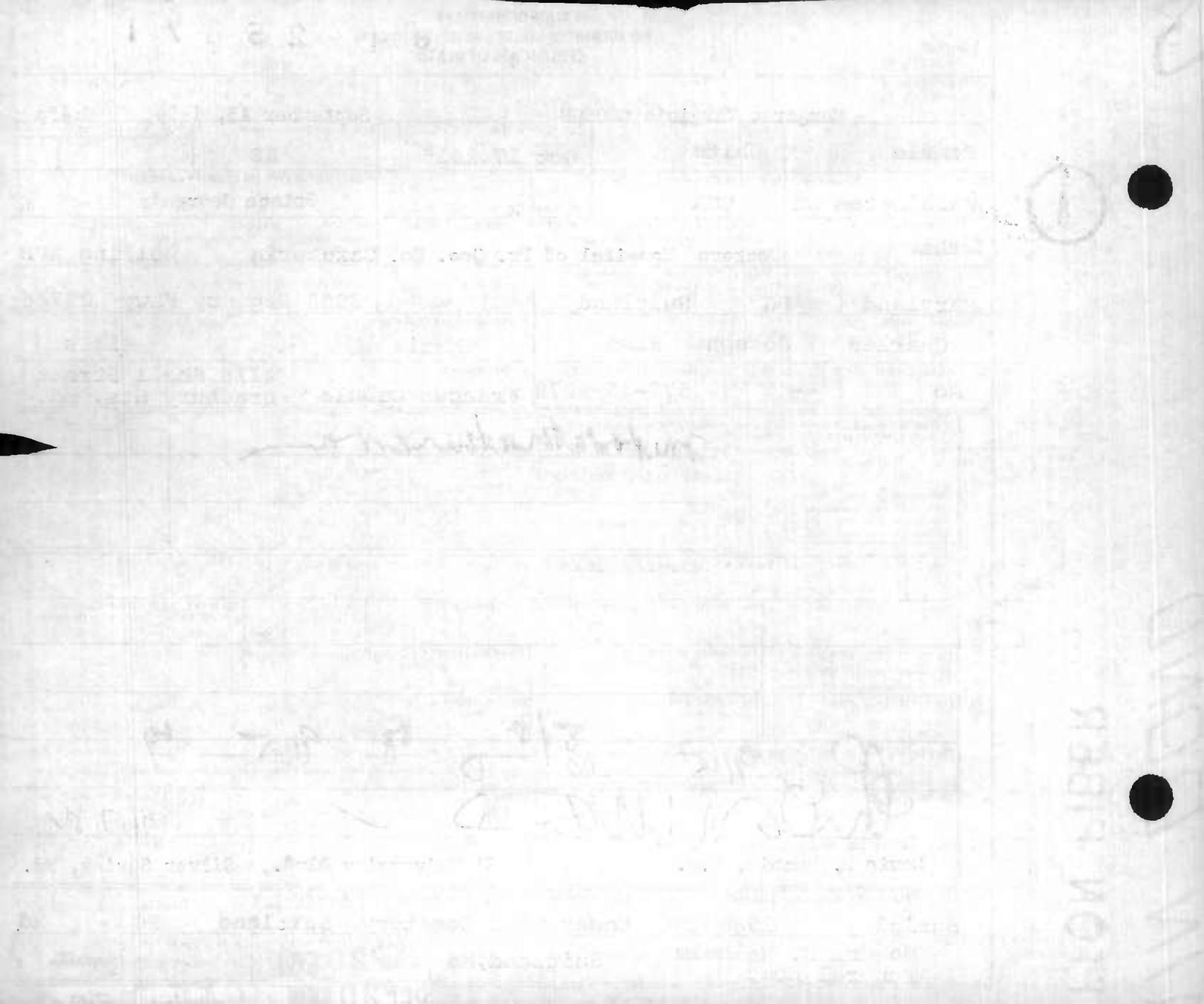
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the offending physician and completely filled in by funeral director, page 3 should be detached for use as the burial/trans permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT.** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25471	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Margaret Virginia CROSON						September 15, 1984			9:45p M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct 17, 1915			6. AGE (IN YEARS LAST BIRTHDAY) 68 yrs.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.				
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cafeteria			12b. KIND OF BUSINESS OR INDUSTRY Bolling AFB				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY PG		13c. CITY OR TOWN Suitland			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3906 Regency Pkwy 20746		
14. FATHER'S NAME FIRST Charles		MIDDLE Joseph		LAST Wise			15. MOTHER'S MAIDEN NAME Mazie		LAST Mills		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. --		17. INFORMANT Frances Cebula			18. ADDRESS 4118 Shell Street Bradbury Hts, Md.		APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for 18, 19, and 20.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Motor vehicle accident</u>											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED  WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> at home <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 8/8			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) this hospital _____ ended the deceased from now the deceased never came above (I) he (she) did not die in the body after death.		19 19 19 19			19 19 19 19		to 9/15		that (I) (we) lost		
22b. SIGNATURE <u>Lewis H. Dennis, M.D.</u>		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED 9/17/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis H. Dennis, M.D.		22e. ADDRESS 831 University Blvd., Silver Spring, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 19 Sept 84		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN Suitland		COUNTY PG	STATE Md.	
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm Funeral Home		ADDRESS Suitland, Md.			25a. DATE REC'D. BY REGISTRAR SEP 20 1984		25b. REGISTRAR'S SIGNATURE Julie Davidson-Randall				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon paper. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be held within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certifying physician must sign this section.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25472																	
												REG. NO.																	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR																	
Edward			F.	Cunningham		09-12-84						1: P. M.																	
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR																		
Male			White		MONTH 03 DAY 03 YEAR 20			64 YRS.			MONTHS DAYS HOURS MIN.																		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH																					
PA			U.S.A.					Prince Georges County MD.																					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY																				
Riverdale			Leland Memorial Hospital			FED. supervisor of pathology GOV'T																							
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET ADDRESS / ZIP CODE			20912															
MD.			MONTG.		TAKOMA PARK						7710 MAPLE AVE. #701																		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST																		
EDWARD			CUNNINGHAM			MARY			PLOWER																				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS																				
YES			WWII 176-18-7158			MARIE CUNNINGHAM (SAME AS ITEM 13)																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Intra cerebral hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE														
22a. I certify that (I) (this hospital) attended the deceased from 9-8-1984 to 9-12-1984, that (I) (we) last saw the deceased alive on 9-12-1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															22b. SIGNATURE <u>R Nath</u>														
															DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9-12-1984		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS <u>4430 3715 Rhode Island Ave., Mt. Rainier, Md. 20712</u>																										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 9-17-1984			23c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NAT'L CEM. ARLINGTON, VA.			23d. LOCATION CITY OR TOWN			COUNTY			STATE														
24. FUNERAL DIRECTOR NAME			8655 GEORGIA AVE.			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			SEP 17 1984 <u>Jane L. Johnson</u>																				
W. W. CHAMBERS CO. INC, SILVER SPR. Md.																													

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• 112 • 113 • 114 • 115 • 116 • 117 • 118 •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25473				
											REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR				
MAMIE DAVIS						09 07 84						9 55A.M.				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE, (IN YEARS LAST BIRTHDAY) 95 yrs			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.			
FEMALE		WHITE		March 20, 1889												
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.									
VIRGINIA		USA														
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY N/A									
CHEVERLY		PG NURSING CARE CENTER														
13a. STATE MARYLAND		13b. COUNTY Prince George		13c. CITY OR TOWN Oxon Hill			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1313 Southern Ave. 20745						
14. FATHER'S NAME FRANKLIN		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME ELIZA												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. NO * * * *		16c. INFORMANT MR. ANGELO F. DAVIS, 93 Berts Dr. Lothian, Md			ADDRESS 20711									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) DUE TO, OR AS A CONSEQUENCE OF (b) Infected decubiti			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day											
		DUE TO, OR AS A CONSEQUENCE OF (c)			month											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART Ia		Diseases mellitus, coagulase heart failure														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that (I) (the hospital) attended the deceased from saw the deceased alive on		9/16 1984			2/1/1984 to 9/7/1984			and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Don H. Yablonsky, MD		DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/7/84								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Don H. Yablonsky, MD		22e. ADDRESS 10300 Greenbelt Rd # 101 Seabrook														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Sept. 10, 1984		23c. NAME OF CEMETERY OR CREMATORIAL Washington Nat. Cem.			23d. LOCATION CITY OR TOWN Suitland, P.G., Maryland			COUNTY			STATE			
24. FUNERAL DIRECTOR NAME LEE FUNERAL HOME, 6633 Old Alexander Ferry Rd., Clinton, Maryland 20735		25a. DATE REC'D. BY REGISTRAR SFP 14 1984			25b. REGISTRAR'S SIGNATURE Division - McNeill											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										2 5 4 7 4	REG. NO.	
1- STATE REGISTRAR												
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE KNOWN DEATH ESTIMATED		MONTH	DAY	YEAR	2b. HOUR		
RAYMOND		T		DAVIS, Sr.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	9	29	1984	M 11:24 a.m.		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN	2c. DATE PRONOUNCED DEAD		
Male	Black	Dec. 26, 1988	95	8	30					MONTH	DAY	YEAR
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Washington, D.C.		U.S.A.			<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Prince George				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Cheverly		Prince George's General Hospital			Retired			20747				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
Maryland		District Heights				7211 Mason						
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST					
John		Jonathan	Davis	Cora Delaney								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			\$ APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH			
yes		579 34 9262		Dorothy Davis-daughtee-4472 Douglas					N.E.			
18. CAUSE OF DEATH (Enter only one cause per line. (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) Deputy M.D.		MEDICAL EXAMINER								
EXAMINER'S NAME <i>Augusto P. Rodriguez, M.D.</i> ADDRESS <i>5009 Rayburn Ct., Temple Hills, Md.</i>												
23a. BURIAL, CREMATION, REMOVAL SPECIES		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE		
Burial		Oct. 6 1984		Harmony Memorial Park								
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Stewart						Oct. 8 1984		John J. Stewart				
20M 4/82												

270AC

Indoor Survey of your home

Survey

Survey  
Completed

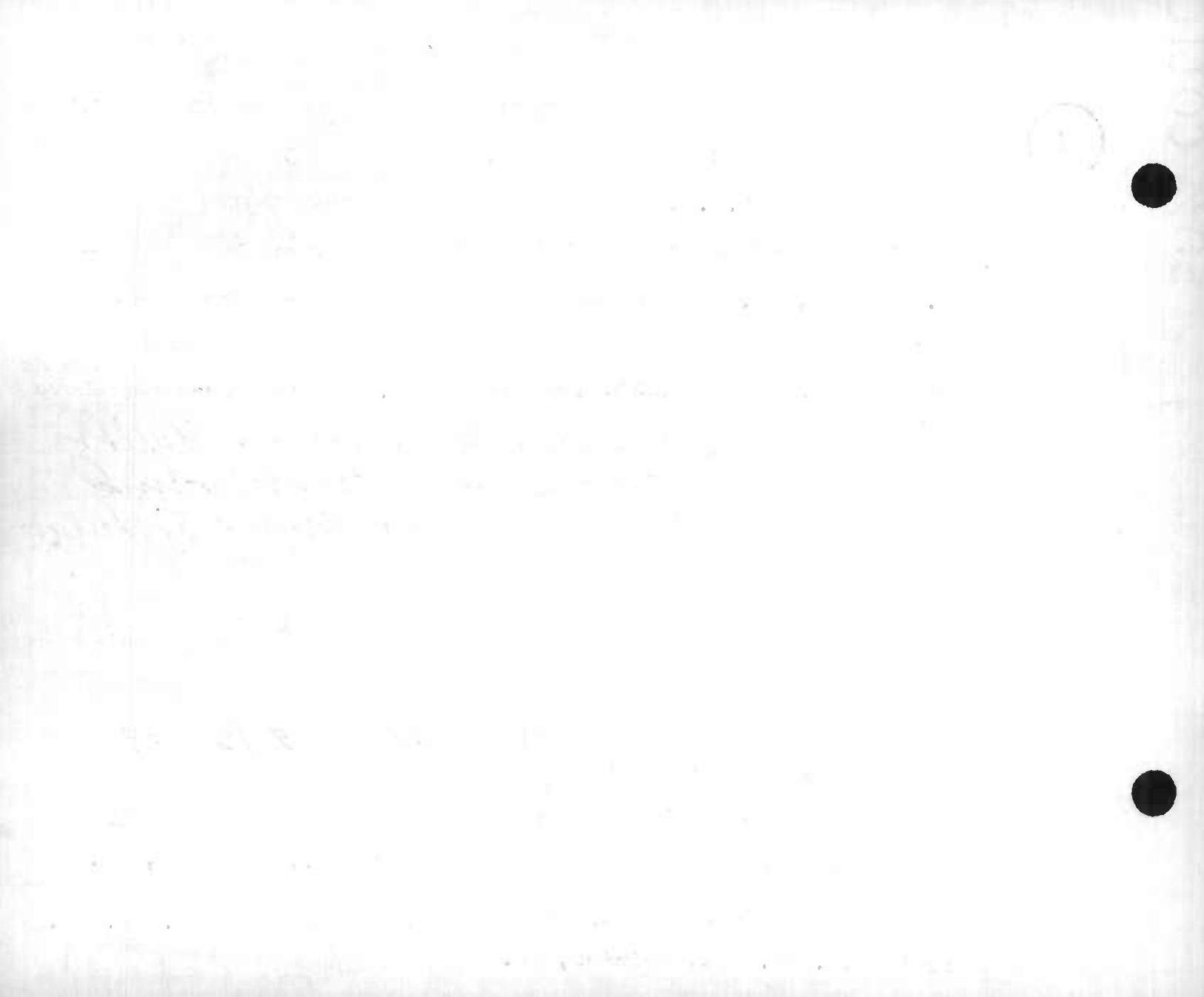
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other traumatic event. The medical examiner must be notified of death.

IMPORTANT: If Item 21 is marked or Item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						25475				
						REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
	ROSARIA DECINTI			09	02	84		10:10AM		
3. SEX	4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female	White		March 8, 1925	59	YRS.	MONTHS	DAYS	HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				PRINCE GEORGES		
Italy	U.S.A.									
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
CHEVERLY	PRINCE GEORGES GENERAL HOSPITAL		Housewife							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									20782	
13a. STATE Md.	13b. COUNTY Pr. Geo.	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2010 - Wardman Rd.						
14. FATHER'S NAME FIRST Saturna	MIDDLE A.	LAST Cappucci	15. MOTHER'S MAIDEN NAME FIRST Antonia	MIDDLE Gizzi	LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT	ADDRESS		Same as				
No	579-86-2427		Gaetano F. Decinti (Husband) above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<p style="text-align: center;">(a) <i>Carcinoma of Colon and Bladder</i>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.</p> <p style="text-align: center;">(b) <i>Extensive intraabdominal metastases and enteric fistulae</i></p> <p style="text-align: center;">(c) <i></i></p>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION <u>9/1/84</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>9/1/84</u> to <u>9/2/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										
22b. SIGNATURE <u>J.C. Shultz, M.D.</u>										
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J.C. Shultz, M.D.</u>	22d. DEGREE			22e. ADDRESS	22f. DATE SIGNED <u>9/2/84</u>					
				6490-Landover Rd., Landover, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9-6-84	23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN	23e. COUNTY	23f. STATE				
24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc.	ADDRESS Mt. Rainier, Md.	25a. DATE REC'D. BY REGISTRAR SEP 10 1984			25b. REGISTRAR'S SIGNATURE <u>John Darden, R.N.</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25476		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Bessie L. Decker						9 14 84						4:35 A.M.		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
F			Caucasian			MONTH Feb. 22, 1895 DAY YEAR			89 89 YRS.			MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS		
Penns.			U.S.A.						Pr. Geo.			HOURS MIN.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			MD.		
Greenbelt			Greenbelt Nursing Home			Housewife						-		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
Md.			Pr. Geo.			College Park						4717-Edgewood Rd. 20740		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
			John		Mowery				Rose		Gardiner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
No			213-74-4404			Robert F. Decker - above address								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												Cardiac arrest (Son) Gastroenterical bleeding		
(b) Due to, or as a consequence of Due to, or as a consequence of												5 days		
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 5/27/84, 19 84, to 9/14, 19 84, that (I) (we) last saw the deceased alive on 9/11, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (I) (we) did not view the body after death.														
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
D. Granite MD												9/14/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23d. LOCATION			23e. REGISTRAR'S SIGNATURE					
D. Granite MD			115 Centerway Greenbelt, Md.			Brentwood Pr. Geo. Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION					
Burial			9/17/1984			Ft. Lincoln Cem.			Brentwood Pr. Geo. Md.					
24. FUNERAL DIRECTOR			NAME			ADDRESS			25. DATE REC'D. BY REGISTRAR					
Nalley's F.H. Inc.						Mt. Rainier, Md.			SEP 20 1984					

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

**TO HOSPITAL OR ATTENDING PHYSICIAN** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 would be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

**STATE OF MARYLAND**

**DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

25477

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Dorothy MIDDLE A.		LAST Dedmon		2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
		<i>Dorothy</i>		<i>Dedmon</i>		<i>9-25-84</i>				<i>10:30 AM</i>	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 2 HRS	
Female		White		Month Day Year 7 6 1900		84		MONTHS	YEARS	HOURS	MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>P.G.</i>					
10 CITY OR TOWN OF DEATH <i>LARGO</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Manor Care Largo</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b KIND OF BUSINESS OR INDUSTRY <i>20782</i>					
13a STATE <i>Md.</i>		13b COUNTY <i>P.G.</i>		13c CITY OR TOWN <i>Bethesda</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <i>6700 Belcrest Rd.</i>		ZIP CODE	
14. FATHER'S NAME FIRST <i>DAVID</i>		MIDDLE <i>S.</i>		LAST <i>Middleton</i>		15. MOTHER'S MAIDEN NAME FIRST <i>MARYANNE</i>		MIDDLE		LAST <i>Miller</i>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>NO</i>		16c		17 INFORMANT RT. 1 Box 2244 Queenstown, Md. <i>M. Carolyn Maul (Daughter)</i>		17b ADDRESS <i>21658</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>72 hours</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sept 15</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Urinary tract infection</i> UNKNOWN											
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Organic Brain syndrome</i>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPST?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)				21f LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a I certify that (the hospital) tendered the deceased from <i>9/18</i> to <i>9/25</i> 1984 (at) (we) last to the physician alive on <i>1984</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I have not seen the body after death.											
22b SIGNATURE <i>[Signature]</i> DEGREE <i>MD</i> ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> DATE SIGNED <i>9/25/84</i>											
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>P SCHIJSSER MD</i>		22e ADDRESS <i>7200 Greenway, CPN PR</i>				22f					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>9/28/84</i>		23c NAME OF CEMETERY OR CREMATORIAL <i>Green Hill Cemetery</i>		23d LOCATION CITY OR TOWN <i>Waynesboro, Penn.</i>		23e DATE REC'D. BY REGISTRAR <i>SEP 28 1984</i>		REGISTRAR'S SIGNATURE <i>John Gardner Pendell</i>	
24 FUNERAL DIRECTOR NAME <i>Hines/Rinaldi</i>		ADDRESS <i>11800 New Hamp.Ave.S.S.M.</i>									



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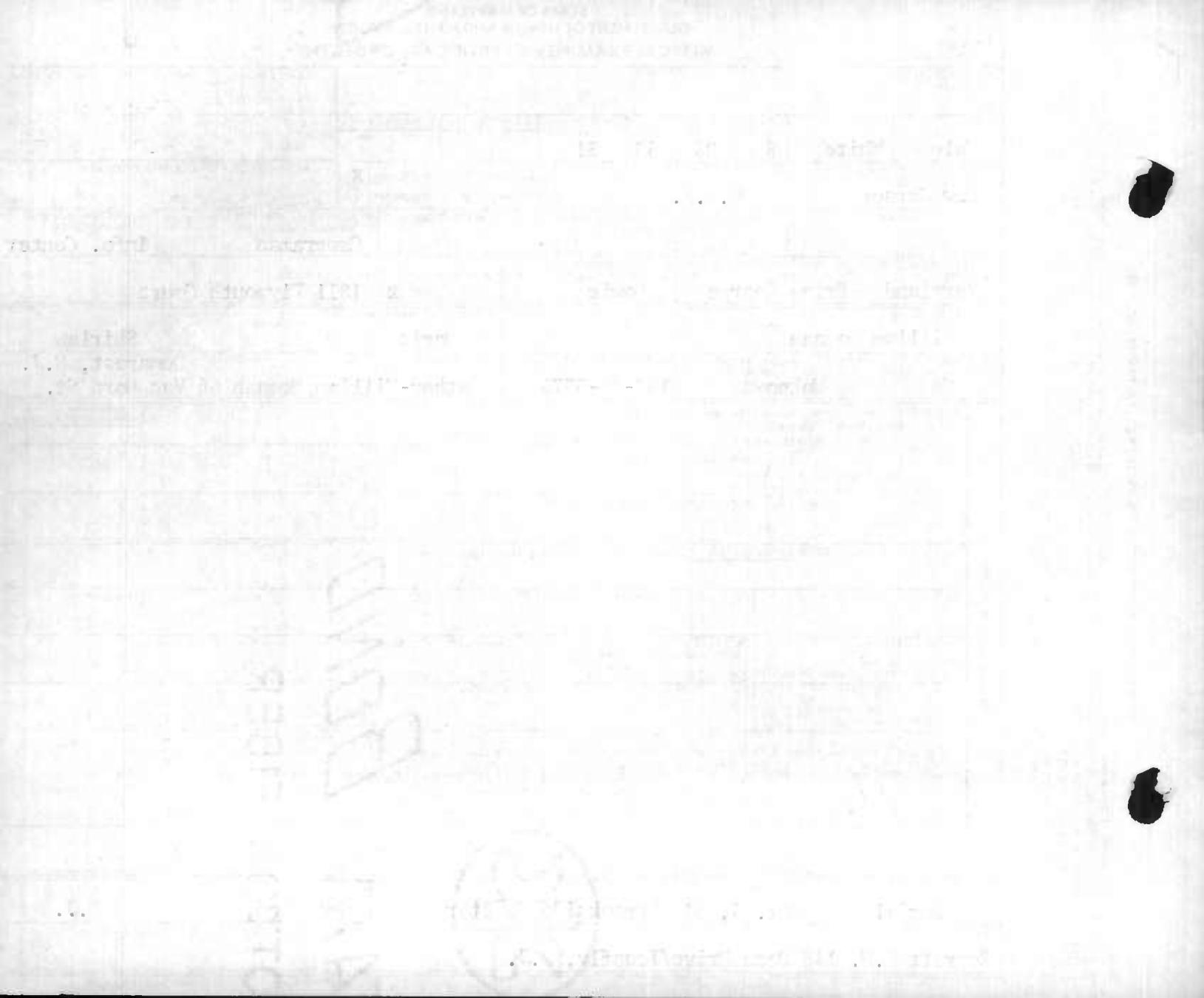
1990-11-10

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

5 478  
REG. NO.

REG NO

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH MATED			MONTH DAY YEAR			2b. HOUR			
William			Degnen			XX			9-29 1984						
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR		2d. HOUR		
Male	White	MONTH DAY YEAR		31 yrs.	MONTHS	DAYS	HOURS	MIN	9-29 1984			7:30 p.m.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH							
New Jersey		U.S.A.						Prince George's County, Md.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Cheverly		Prince George's General Hospital			Cameraman			Info. Center							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						20715									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			MD			
Maryland		Prine George		Bowie		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1811 Plymouth Court						
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
William Degnan						Doris Shirlaw									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)						16b. SOCIAL SECURITY NO.						ADDRESS			
Yes Unknown						152-48-3375						Demarest, N.J.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
8150 IMMEDIATE CAUSE (a) Craniocerebral Trauma															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
4:25xx A.M. 9-29 1984						driver in auto/fixed object impact									
22d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
			road			Central Ave., Kettering, Prince GEorge's Co., Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>Dennis F. Smyth, M.D.</i>												TITLE (SPECIFY) M.D.		DATE SIGNED 10-1-84	
EXAMINER'S NAME (TYPE OR PRINT)			Dennis F. Smyth, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial Oct. 5, 84			23c. NAME OF CEMETERY OR CREMATORIUM Brookside Cemetery			23d. LOCATION CITY OR TOWN Englewood,			COUNTY STATE N.J.			
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR Barrett F.H. 148 Dean Drive/Tenafly, N.J.			25b. REGISTRAR'S SIGNATURE						
						Oct. 5, 1984									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Film G 595 Items #5, #6, 15  
FOR 9/18/84 rja  
1 - STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

25479

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST DON	MIDDLE J	LAST DILEY	2a DATE OF DEATH MONTH 9 DAY 1 YEAR 84	2b HOUR 29.49pm
3. SEX <b>Male</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH 9 DAY 25 YEAR 1928		6 AGE (IN YEARS AT LAST BIRTHDAY) 55	IF UNDER 1 YEAR MONTHS YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES COUNTY MD.</b>	
10 CITY OR TOWN OF DEATH <b>CLINTON MD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>SOUTHERN MARYLAND HOSPITAL</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Military</b>	
13a STATE <b>Maryland</b>			13b COUNTY <b>Pr. George</b>	13c CITY OR TOWN <b>Clinton</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>9612 Small Dr. 20735</b>	
14. FATHER'S NAME FIRST <b>Henry</b>			MIDDLE <b>F.</b>	LAST <b>Diley</b>	15 MOTHER'S MAIDEN NAME FIRST <b>Dorothy</b>	MIDDLE <b>Jamison</b> LAST <b>Collier</b>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>			16b SOCIAL SECURITY NO. <b>1946-1966 235-36-2156</b>		17. INFORMANT <b>Marion J. Diley same as item 13</b>	ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line for part I, II, and III) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis &amp; Abdominal abscess</b> 2wks							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2wks</b>							
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ulcerative colitis</b> 2months							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>Myocardial infarction - Diabetes Mellitus</b>							
19a. DATE OF OPERATION <b>8-1-84</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Perforated colon - bypass</b>		19c. AUTOPSY <b>Small intestine</b>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (FILER NOTIFY MEDICAL EXAMINER)		21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21b. HOW INJURY OCCURRED NATURE OF INJURY IN ITEM 20a PART I OR PART II <b>stabbed</b>		21c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED HOME <input type="checkbox"/> NOT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>7-21-84</b> to <b>9-1-84</b> , that (I) (we) last saw the deceased alive on <b>9-1-84</b> and that in (my) <b>opinion</b> death occurred on the date and hour and from the causes stated above. (I) <b>did not</b> (did not) view the body after death.							
22b. SIGNATURE <b>T.F. Cleary M.D.</b>							
22c. DEGREE <b>M.D.</b>							
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. DATE SIGNED <b>9-2-84</b>							
22e. ADDRESS <b>3611 Branch Ave. Hillcrest Hights, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/6/84</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington Nat. Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Arlington</b>	
24. FUNERAL DIRECTOR NAME <b>G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md. SFPO</b>							
ADDRESS <b>6160 Oxon Hill Rd. Oxon Hill, Md. SFPO</b>							
25a. DATE REC'D. BY REGISTRAR <b>5-18-84</b>							
25b. REGISTRAR'S SIGNATURE <b>Julie Davidson-Pendleton</b>							

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strategic  
Mr. George  
Cityplan  
68-15 Grand  
St. So. 3

As a result, the `get` method returns a `Promise` object that is resolved with the value returned by the `get` method.

3611 Prisoner of War. Hitler's first major strategic mistake.

• FV

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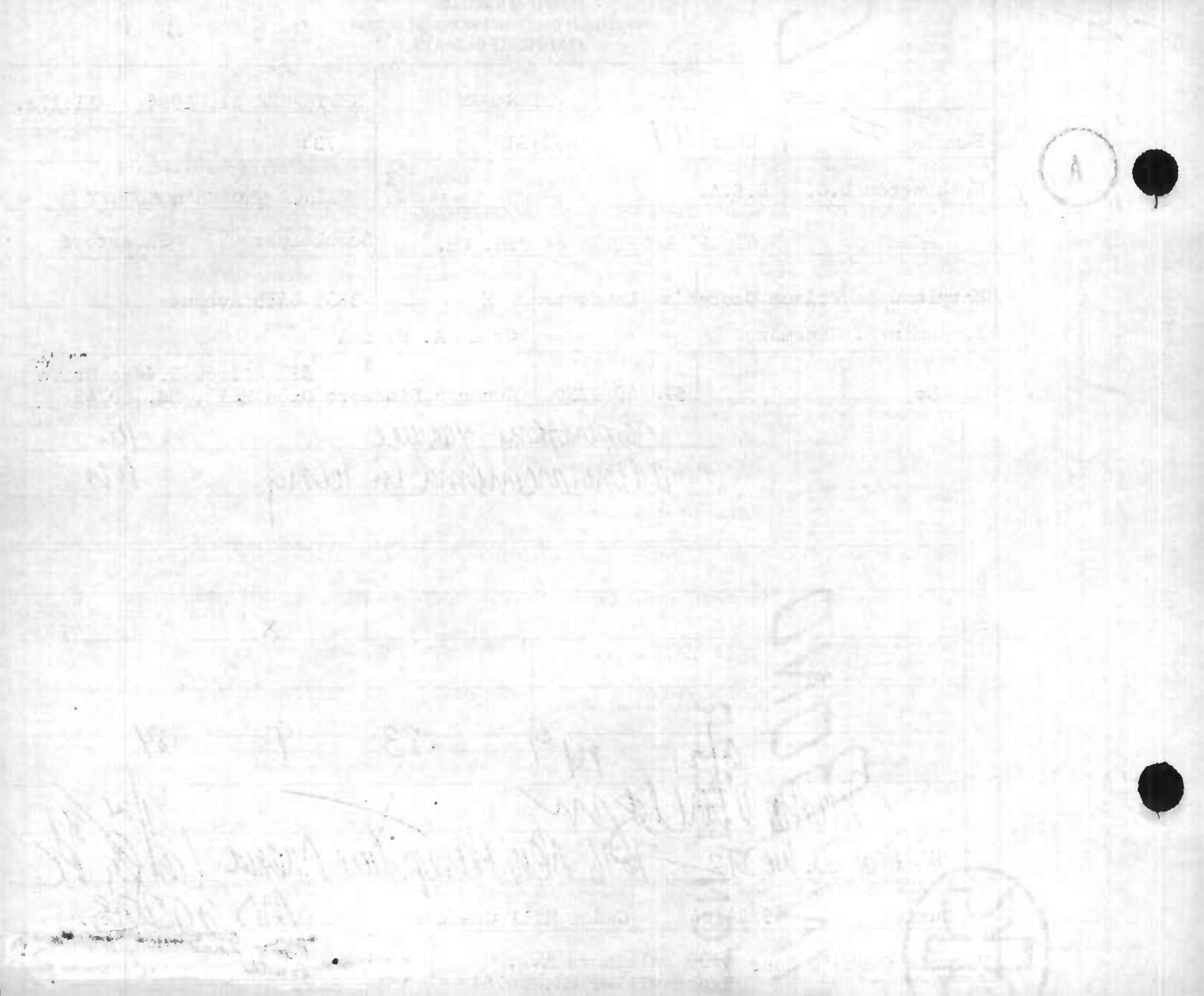
•5% (If not) or 11% (not) paid after 4.3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Box 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be delivered directly to the funeral home. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25480
1 - FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR								REG. NO.
I. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2b. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
MARY A. DINSMORE							SEPTEMBER 21, 1984				11:17AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
Female		White		8/17/31			53					
9a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9c. BALTIMORE CITY OR COUNTY OF DEATH	
Washington D.C.		U.S.A.									PRINCE GEORGE's COUNTY MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
LANHAM		DOCTORS' HOSPITAL of P.G. CO.		Bookkeeper			Shoestore		20784			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS / ZIP CODE			
Maryland		Prince George's		Landover			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3839 64th Avenue			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			ADDRESS				
Benjamin F. Dinsmore					Grace A. Wenzel			517 Wilson Bridge Drive				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			Kenneth Dinsmore		Oxon Hill, Md. 20745		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No		578 40 9230									1m m	
18. CAUSE OF DEATH (Enter only one cause per line for item 18b, 18d & 18e) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a):												
respiratory failure adeno carcinoma in lung												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b): (b): DUE TO, OR AS A CONSEQUENCE OF: (b): DUE TO, OR AS A CONSEQUENCE OF: (c):												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this Hospital) attended the deceased from: 9/21/84 show the deceased alive on: 9/21/84 and that (I) (we) did (not) view the body after death.		19 83 10 9 19 84										
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
MAURIN D. WENTZ		7076 New Hampshire Avenue Langley PK										
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		23e. STATE			
Burial		9/24/84		Cedar Hill Cemetery			Suitland		MD			
24. FUNERAL DIRECTOR (NAME) Francis Gasch's Sons 4739 Baltimore Ave. Hyattsville, Md. 20781												
25. DEATH CERTIFIED John Gardner Randall												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
RICHARD			E.	DUCKETT		Sept. 15	1984			1:15 P.M.			
3. SEX			4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Male			Black	10	- 27 -	1900	83						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland			U.S.A.					Prince George					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Clinton			So...Md., Hosp. Center			Laborer			Farming				
13a. STATE			13b. COUNTY	13c. CITY, OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
Md.			P.G.	Clinton				2911 Stewart Lane 20735					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Richard Dackett			Charity Jenkins										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No			216-38-6269			Gertrude Duckett							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, b, and c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause per line for 1a, b, and c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first			DUE TO, OR AS A CONSEQUENCE OF (c) Inflammation Gastro O.T. Bleeding										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED	
22b. SIGNATURE <i>M. Mostagin</i>		22d. DEGREE PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 9/20/84		23c. NAME OF CEMETERY OR CREMATORIAL Resurrection Cemetery, Clinton, P.G. Md.		23d. LOCATION Cemetery			25a. DATE REC'D. BY REGISTRAR 1984			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>	
24. FUNERAL DIRECTOR NAME Martell Adams - Aquasco, Md.		ADDRESS											

3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 25482		
1 - FOR STATE REGISTRAR			I. DECEASED NAME FIRST FEMALE			MIDDLE EDMONDS			2a. DATE OF DEATH 08-06-84			2b. HOUR 12 03PM		
3. SEX FEMALE			4. RACE BLACK			5. DATE OF BIRTH MONTH 08 DAY 06 YEAR 84			6. AGE (IN YEARS LAST BIRTHDAY) MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			7. IF UNDER 1 YEAR MONTHS 3 DAYS 20 YRS.		
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY MD.			7b. CITIZEN OF WHAT COUNTRY?			8.			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.					
10. CITY OR TOWN OF DEATH CHEVERLY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSP.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 00000		
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMATURE												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 HRS		
IMMATURE												3 HRS		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b) IMMATURE														
DUE TO, OR AS A CONSEQUENCE OF (c) IMMATURE														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8/6/84 to 8/6/84, that (I) (we) last saw the deceased alive on 8/6/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.														
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/6/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			PRINCE GEORGE'S GEN HOSP, CHEVERLY, MD					
23a. BURIAL, CREMATION, REMOVAL			23b. DATE 9/25/84			23c. NAME OF CEMETERY OR CREMATORIUM Prince George's Hosp.			23d. LOCATION TOWN					
24. FUNERAL DIRECTOR			Raleigh Cline, Cheverly, MD 20785			25. DATE REC'D. BY REGISTRAR 01/08/84			25. REGISTRAR'S SIGNATURE John Davidson-Pender					

Stepie Gline, Chivas, D. 28492

medication, also a good, hard, chewable, no mouth

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 25483					
1. DECEASED NAME (TYPE OR PRINT)			FIRST CARL	MIDDLE W	LAST EDWARDS			2a. DATE OF DEATH MONTH SEPTEMBER 15, 1984			2b. HOUR 02:25pm				
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>March</b> DAY <b>8</b> YEAR <b>1918</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b>		IF UNDER 1 YEAR MONTHS <b>YRS</b>			IF UNDER 24 HRS MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD.								
10. CITY OR TOWN OF DEATH <b>Andrews Air F.B. Camp Springs</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Malcolm Grow Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Air Force-Retired</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Military</b>								
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince George</b>		13c. CITY OR TOWN <b>Forestville</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>7800 D'arcy Road 20747</b>						
14. FATHER'S NAME FIRST <b>Charles</b>		MIDDLE <b>Edwards</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Icie</b>			MIDDLE <b>Maxine</b>		LAST <b>Sheets</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WVII-Korea 577-52-4145</b>		17. INFORMANT <b>Margaret Edwards</b>			ADDRESS <b>7800 Darcy Road Forestville, Maryland</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>															
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that <b>(he/his hospital)</b> attended the deceased from <b>15 Sep 84</b> , 19 <b>84</b> , to <b>15 Sep 84</b> , 19 <b>84</b> , that (s) (he/she) lost saw the deceased alive on <b>19</b> , 19 <b>84</b> , and that in (my) <b>(his/her)</b> opinion death occurred on the date and hour and from the causes stated above. (s) (he/she) did not view the body after death.															
22b. SIGNATURE <b>Roy M. Krings</b>		22c. DEGREE			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22e. DATE SIGNED <b>15 Sep 84</b>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Roy M. Krings</b>		22e. ADDRESS <b>MALCOLM GROW USAF MEDICAL CENTER, AAFB, MD</b>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/20/84</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National Cem.</b>			23d. LOCATION CITY OR TOWN <b>Arlington</b>		23e. COUNTY <b>Virginia</b>						
24. FUNERAL DIRECTOR NAME <b>George P. Kalas Funeral Home Oxon Hill, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>6160 Oxon Hill Rd.</b>			25b. REGISTRAR'S SIGNATURE <b>Julie Sanderson-Fordell</b>										

met een goed voorbeeld

kan ik u de verschillende soorten van woorden toelichten.

Tegenwoordig

wordt veel

gebruikt om een woord te beschrijven.

Als voorbeeld kan ik u

de verschillende soorten van woorden toelichten.

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de verschillende soorten van woorden toelichten.

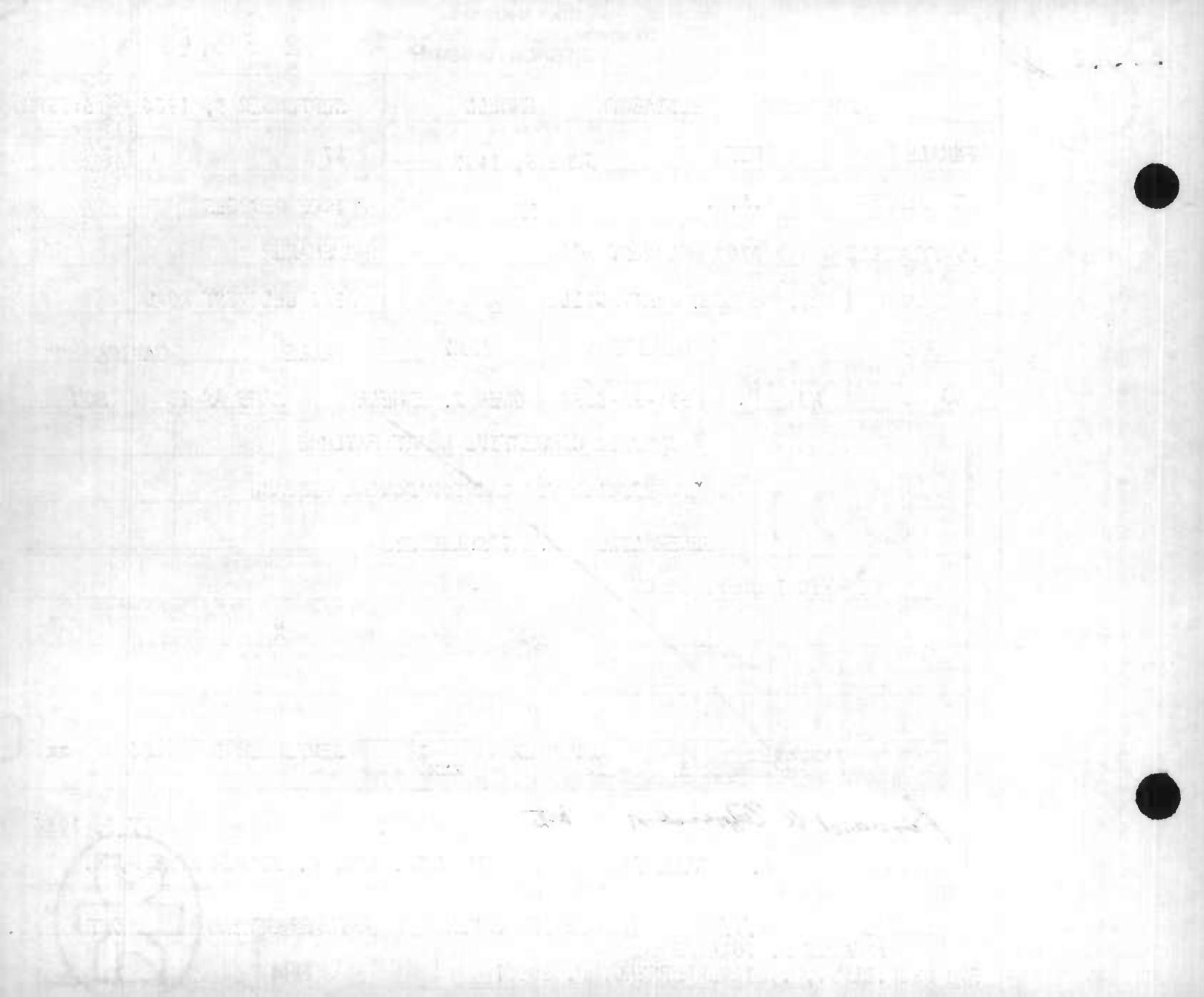
Als voorbeeld kan ik u

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

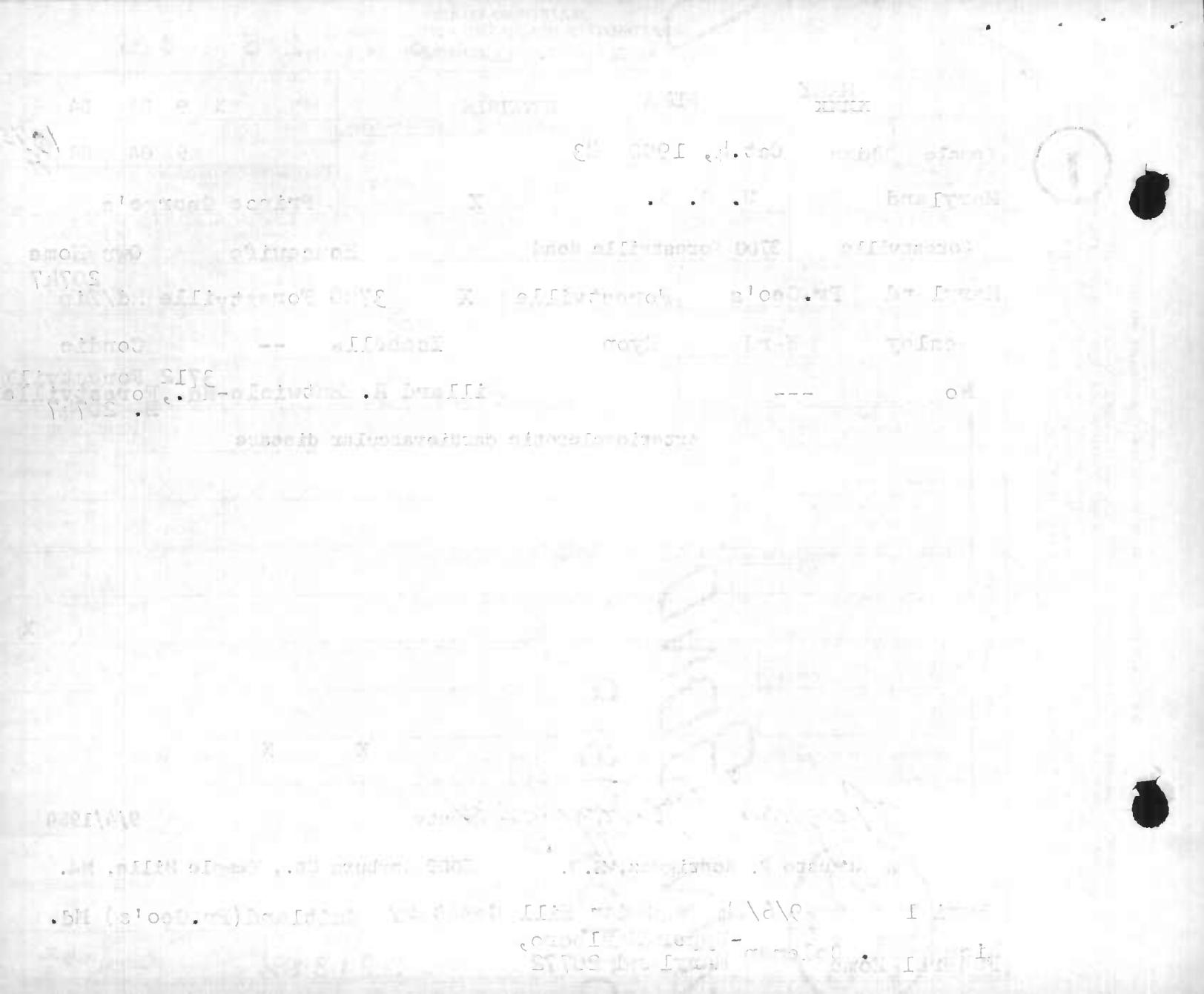
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25484		
												REG. NO.		
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			MARGARET ELIZABETH EMMELL						SEPTEMBER 3, 1984			6:55PM		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			# UNDER 1 YEAR		
FEMALE			WHITE			JUNE 5, 1897			87			MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			# UNDER 24 HRS		
NEW JERSEY			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			PRINCE GEORGES			MONTHS DAYS HOURS MIN.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
HYATTSVILLE			6700 BELCREST ROAD			HOMEMAKER								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
MARYLAND		PRI. GEORGES		HYATTSVILLE					6700 BELCREST ROAD			20782		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
OWEN MCKENNA			MARY ELLEN GAVIGAN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO			579-58-3054			OWEN J. EMMELL			SAME AS 13 SON					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)												CHRONIC CONGESTIVE HEART FAILURE		
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ARTERIOSCLEROSIS														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
HEPATIC INSUFFICIENCY														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from NOVEMBER 19 79 to SEPTEMBER 3 19 84, that (I) <input checked="" type="checkbox"/> saw the deceased alive SEPTEMBER 3 19 84, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.														
22b. SIGNATURE <i>Bernard A. Fitzgerald</i>												22c. DATE SIGNED Sept 3, 1984		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
BERNARD A. FITZGERALD			217 UNIV. BLVD., E., SILVER SPRING, MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL			8/17/84			GATE OF HEAVEN			SILVER SPRING MONT MD.					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
FRANCIS J. COLLINS			500 UNIV. BLVD., W., SILVER SPRING, MD. 20901			SEP 5 1984			<i>Johanna J. Fitzgerald</i>					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, AND 3 TO THE FUNERAL DIRECTOR.  
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3, RETAIN PAGE 5 FOR YOUR FILES.  
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

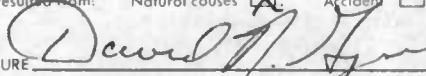
## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												2 5 4 8 5 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>MARY</b> <del>ZEBRA</del>	MIDDLE <b>EDNA</b>	LAST <b>ENTWISLE</b>	2a DATE KNOWN OF ESTI- DEATH MATED			□ MONTH 9 04 1984	DAY YEAR	2b HOUR 10:45 AM		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS	7. IF UNDER 1 YR. MONTHS 0	8. IF UNDER 24 HRS. DAYS 0	9. HOURS 0	10. MIN 0	2c. DATE PRONOUNCED DEAD			9 04 1984	11. HOUR 10:45 AM	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED X		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH			Prince George's MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Forestville		3700 Forestville Road				Housewife				Own Home			
13a. STATE Maryland		13b. COUNTY Pr. Geo's		13c. CITY OR TOWN Forestville		13d. INSIDE CITY LIMITS? YES X		13e. STREET ADDRESS 3700 Forestville Rd/Zip				20747	
14. FATHER'S NAME FIRST <b>Wesley</b>		MIDDLE <b>Ward</b>		LAST <b>Ryon</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Isabella</b>		16. ADDRESS Willard R. Entwistle-Rd., Forestville				Condie	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			---			Willard R. Entwistle-Rd., Forestville			3712 Forestville Rd., Forestville			28 days	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gove rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Augusto P. Rodriguez, M.D.</i>		M.D. Deputy MEDICAL EXAMINER										DATE SIGNED 9/4/1984	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 5009 Rayburn Ct., Temple Hills, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 9/16/84			23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN Suitland (Pr. Geo's) Md.			COUNTY STATE	
24. FUNERAL DIRECTOR Richard A. Coleman Funeral Home			-Upper Marlboro, Maryland 20772			25a. DATE REC'D. BY REGISTRAR SEP 13 1984			25b. REGISTRAR'S SIGNATURE <i>L. Davidson-Randall</i>				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2 5 4 8 6				
1 - STATE REGISTRAR																
I. DECEASED NAME (TYPE OR PRINT)			FIRST James			MIDDLE Enrin			LAST Ennis			2a. DATE KNOWN OF ESTI- DEATH MATED	2b. MONTH MONTH	2c. DAY DAY	2d. YEAR YEAR	2e. HOUR HOUR
3. SEX M			4. RACE W			5. DATE OF BIRTH MONTH 08 DAY 09 YEAR 02			6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.			IF UNDER 1 YR.	IF UNDER 24 HRS.			15:02 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? USA.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.				
10. CITY OR TOWN OF DEATH LaPlata			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Mem'l Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sgt.			12b. KIND OF BUSINESS OR INDUSTRY Police Dept.							
13a. STATE Florida			13b. COUNTY Manatee			13c. CITY OR TOWN Palmetto			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 158 Lafayette Colonial Mobil			Home Park		
14. FATHER'S NAME FIRST Unknown			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST Unknown		MIDDLE			LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 577 36 3774			17. INFORMANT Mary Ennis-See #13 above			ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Ventricular Fibrillation DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held an			Autopsy <input type="checkbox"/>			Inspection <input checked="" type="checkbox"/>			Inquiry <input checked="" type="checkbox"/>			and in my opinion				
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE 			M.D.			TITLE (SPECIFY) Acting			MEDICAL EXAMINER			DATE SIGNED 9/19/84				
EXAMINER'S NAME (TYPE OR PRINT) DAVID N. GINGRICH			ADDRESS 5019 Woodhaven Dr., LaPlata MD 20646													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Sept. 24 1984			23c. NAME OF CEMETERY OR CREMATORIAL Palmetto Crematory			23d. LOCATION CITY OR TOWN Palmetto, Florida			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes, Arlington, Va22201			ADDRESS			25a. DATE REC'D. BY REGISTRAR SEP 24 1984			25b. REGISTRAR'S SIGNATURE Julie Davidson-Randall							
20M 4/B2																
DHMH - 17 (VR A15 ME (5))																
20M 4/B2																



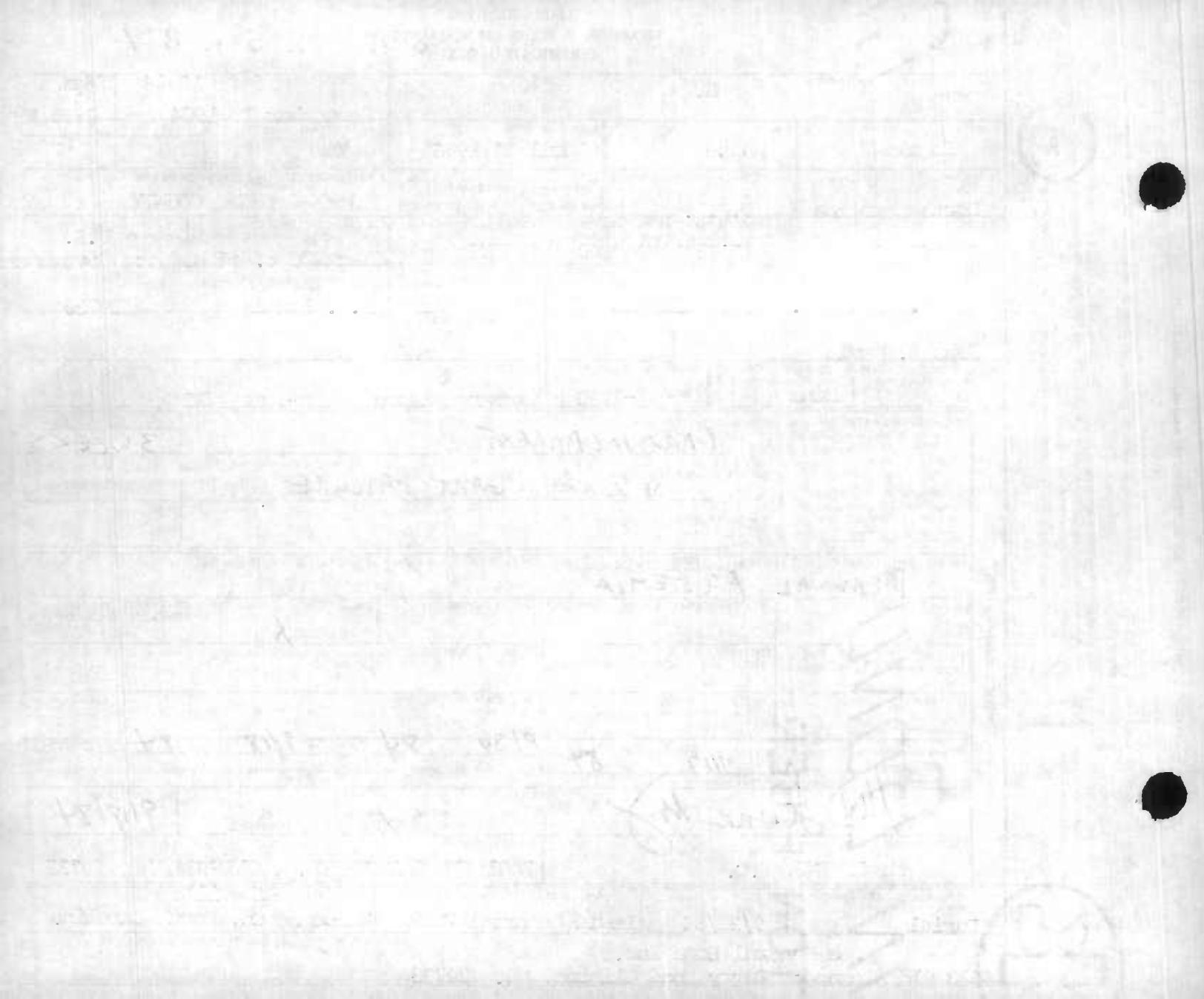
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or one of the following should be done:

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					25481
					REG. NO.
1. DECEASED NAME (TYPE OR PRINT)	RUTH	MIDDLE H.	BURTON		2d. DATE OF DEATH 9 MONTH 18 84 <sup>AR</sup> 8:58pm
3. SEX	Female	4. RACE	White	5. DATE OF BIRTH MONTH DAY YEAR	September 18, 1984 8:58 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	North Carolina	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	6. AGE (IN YEARS LAST BIRTHDAY) 78	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
10 CITY OR TOWN OF DEATH	CLINTON MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.
13a. STATE Md.	13b. COUNTY P.G.	13c. CITY OR TOWN Clinton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE P.O. Box 29 20735	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk Dept. of Defense Government
14. FATHER'S NAME FIRST John R. Davis	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Maude Bassett	MIDDLE	LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None	17. INFORMANT Barbara Nisson	ADDRESS Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE HEART FAILURE</u>					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>PREGNATAL AZOTEMIA</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET	CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>9/17</u> to <u>8/4</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did) (do) not view the body after death.					
22b. SIGNATURE <u>M.D. Levine M.D.</u>	22c. DEGREE			22d. DATE SIGNED 9/18/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
M. LEVINE, M.D.			22e. ADDRESS 7801 OLD BRANCH AVE., CLINTON, MD. 20735		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE 9/22/84	23c. NAME OF CEMETERY OR CREMATORIAL Lewis Memorial Park		23d. LOCATION Asheville CITY OR TOWN Buncombe Co. North Carolina	STATE
24 FUNERAL DIRECTOR NAME	Lee Funeral Home Inc.			25a. DATE REC'D. BY REGISTRAR SEP 20 2010	25b. REGISTRAR'S SIGNATURE <u>Lee Funeral Home Inc.</u>
6633 Old Alexander Ferry Road Clinton, Md. 20735					



**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

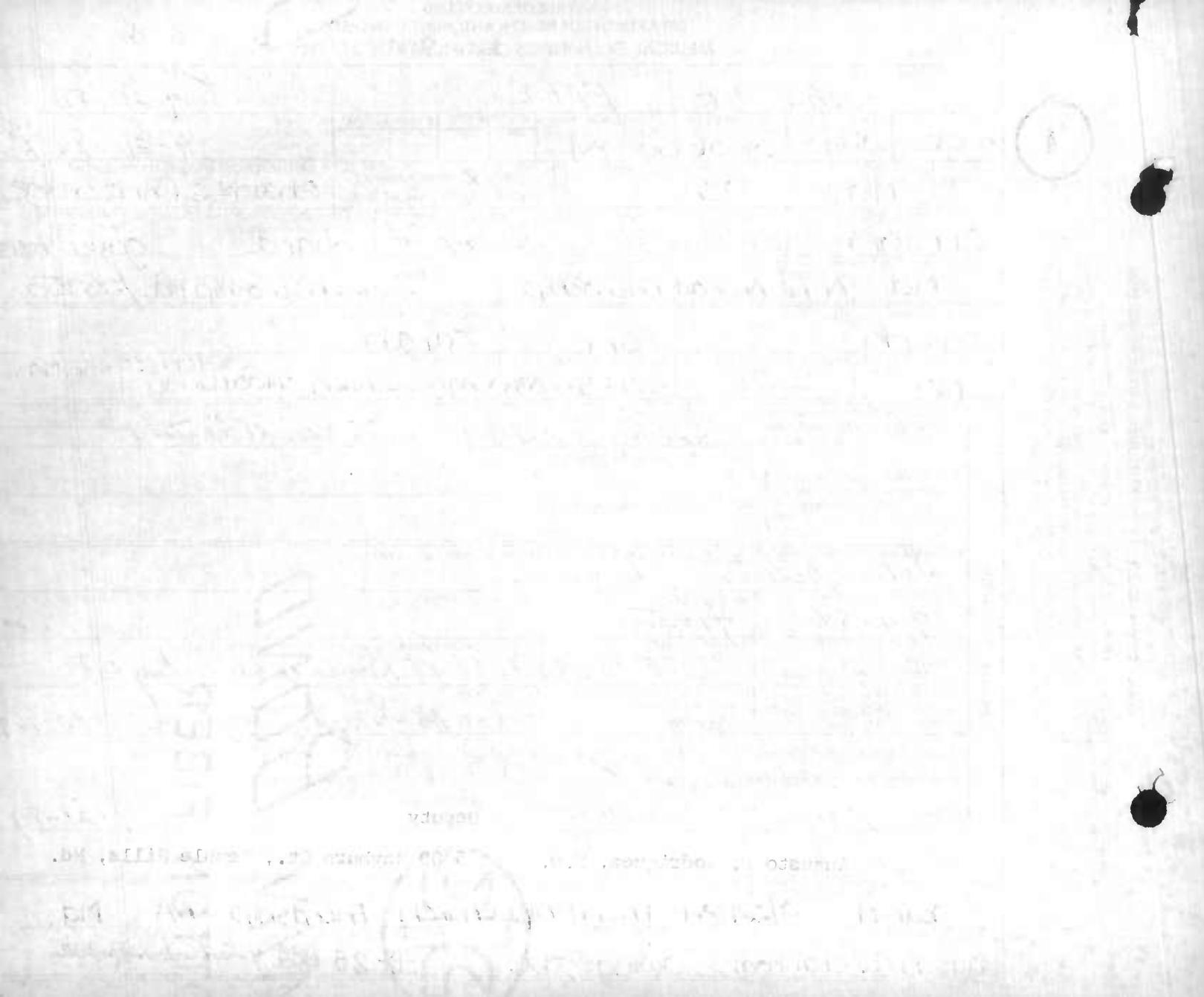
5 488

REG. NO.

VISION REVITAL RECORDS 201 W PRESTON ST BALTIMORE MD 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3 RETAIN PAGE 5 FOR OUR FILE. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PATTERSON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)				FIRST <i>John A</i>	MIDDLE <i>PARR</i>	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH DAY YEAR <i>9-21 1984</i>	2b. HOUR
3. SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH MONTH <i>01</i>	DAY <i>06</i>	YEAR <i>84</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>84 yrs.</i>	IF UNDER 1 YR. <input type="checkbox"/>	IF UNDER 24 HRS. <input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN.	7c. DATE PRONOUNCED DEAD <i>9-21 1984</i>	MONTH DAY <i>9-21 1984</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Charles Prince George</i>	
10. CITY OR TOWN OF DEATH <i>Clinton</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN HOSPITAL FACILITY, GIVE STREET ADDRESS) <i>Southern Maryland Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>guard</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>government</i>	
13a. STATE <i>Md.</i>		13b. COUNTY <i>Anne Arundel</i>	13c. CITY OR TOWN <i>Friendship</i>		13d. INSIDE CITY LIMITS <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET ADDRESS <i>#4 Friendship Rd./20758</i>			
14. FATHER'S NAME FIRST <i>Joseph</i>		MIDDLE <i>—</i>	LAST <i>Farr</i>		15. MOTHER'S MAIDEN NAME FIRST <i>sarah</i>		MIDDLE <i>—</i>	LAST <i>—</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>517-56-0360</i>		17. INFORMANT <i>Agnes L. Aiken</i>		ADDRESS <i>7400 Marion St., Forrestville, Md.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <i>8880</i>		IMMEDIATE CAUSE (a) <i>Left hip fracture with complications</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Dysteniasis, dementia, fracture</i>									
19a. DATE OF OPERATION <i>9-4-84</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>fracture</i>						20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>8-30 84</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) <i>fell at home while walking out</i>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i>		21f. LOCATION STREET <i>7400 Marion St., Forrestville, Md.</i>		CITY OR TOWN <i>Forrestville, Md.</i>	COUNTY <i>30747</i>	STATE <i>—</i>	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) <i>Deputy</i>		MEDICAL EXAMINER		DATE SIGNED <i>9-21-84</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>		ADDRESS <i>5009 Rayburn Ct., Temple Hills, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>9/24/84</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Friendship church</i>		23d. LOCATION CITY OR TOWN <i>Friendship AA</i>		23e. COUNTY <i>Md.</i>	23f. STATE <i>—</i>	
24. FUNERAL DIRECTOR NAME <i>Rausch Funeral Home</i>		ADDRESS <i>Owings, Md.</i>	25a. DATE REC'D. BY REGISTRAR <i>SEP 26 1984</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pandell</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the deceased is admitted to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 25489														
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR								2b. HOUR															
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE		LAST			Sept. 14, 1984			7:30 AM												
BARBARA P. FINK																										
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS											
Female			Caucasian			Sept. 14, 1926			58 YRS.			MONTHS DAYS			HOURS MIN											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.														
New York			USA						Prince George's County																	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY												
Beltsville			13017 Ingleside Drive								Registered Nurse Nursing			20705												
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			20705												
Maryland			Prince George		Beltsville						13017 Ingleside Drive															
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST											
Benjamin F. Fink									Hazel						Drumm											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			Beltsville, Md.														
Yes			Korean 151-14-7927						Betty Ritchie, Friend, 13017 Ingleside Dr.,			/														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Progressive recurrent progressive brain tumor</i>															APPROXIMATE TIME BETWEEN ONSET AND DEATH <i>20705</i>											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b).																										
DUE TO, OR AS A CONSEQUENCE OF (c).																										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																										
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?														
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 3, 1984</u> to <u>Sept. 14, 1984</u> , that (I) (we) last saw the deceased alive on <u>Aug. 9, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																										
22b. SIGNATURE <i>Bruce W. Booth MD</i>															DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>Sept. 14, 1984</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23a. BURIAL, Crematory (SPECIFY)			23b. DATE Sep. 17, 1984			23c. NAME OF CEMETERY Arlington National			23d. LOCATION CITY OR TOWN <i>Arlington, Virginia</i>			COUNTY STATE								
Burial																										
24. FUNERAL DIRECTOR NAME W. W. Chambers Co., 8655 Georgia Ave., Silver Spring, Md. 20910			25a. DATE REC'D. BY REGISTRAR SEP 17 1984			25b. REGISTRAR'S SIGNATURE <i>Jean Larson-Purcell</i>																				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25490					
REG. NO.																	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
GEORGE			E.	FINK		09			20	84		8:00AM					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male		Cau.		2	11	1933	51			YRS.	MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
Pennsylvania		U.S.A.					PRINCE GEORGES			MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
CHEVERLY		PRINCE GEORGES GENERAL HOSPITAL			Sales Rep.												
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE MD.		13b. COUNTY P.G.		13c. CITY OR TOWN Laurel			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 9551 Muyrkirk Rd.		20746					
14. FATHER'S NAME FIRST George			MIDDLE E.	LAST Fink	15. MOTHER'S MAIDEN NAME FIRST Lucille			MIDDLE	LAST Unger								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) No.			17. INFORMANT Jenny Fink			ADDRESS 9551 Muyrkirk Rd.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Cancer												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.																	
(b) _____																	
DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9-16</u> , 19 <u>84</u> , to <u>9-20</u> , 19 <u>84</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>9-20</u> , 19 <u>84</u> , and that in (my) ( <input checked="" type="checkbox"/> ) opinion death occurred on the date and hour and from the causes stated above, ( <input checked="" type="checkbox"/> ) we ( <input checked="" type="checkbox"/> ) did ( <input checked="" type="checkbox"/> ) view the body after death.												22c. DATE SIGNED <u>9-20-84</u>					
22b. SIGNATURE <u>B. Epstein</u>												22d. DEGREE <u>MD</u>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY EPSTEIN, MD												ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial		23c. NAME OF CEMETERY OR CREMATORIAL Church Cemetery			23d. LOCATION CITY OR TOWN Hanover, Pa.			COUNTY	STATE						
24. FUNERAL DIRECTOR NAME J.B. Jenkins												25a. DATE REC'D. BY REGISTRAR OCT 3 1984			25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Renfrew</u>		
ADDRESS 7474 Landover Rd. Landover, MD.																	



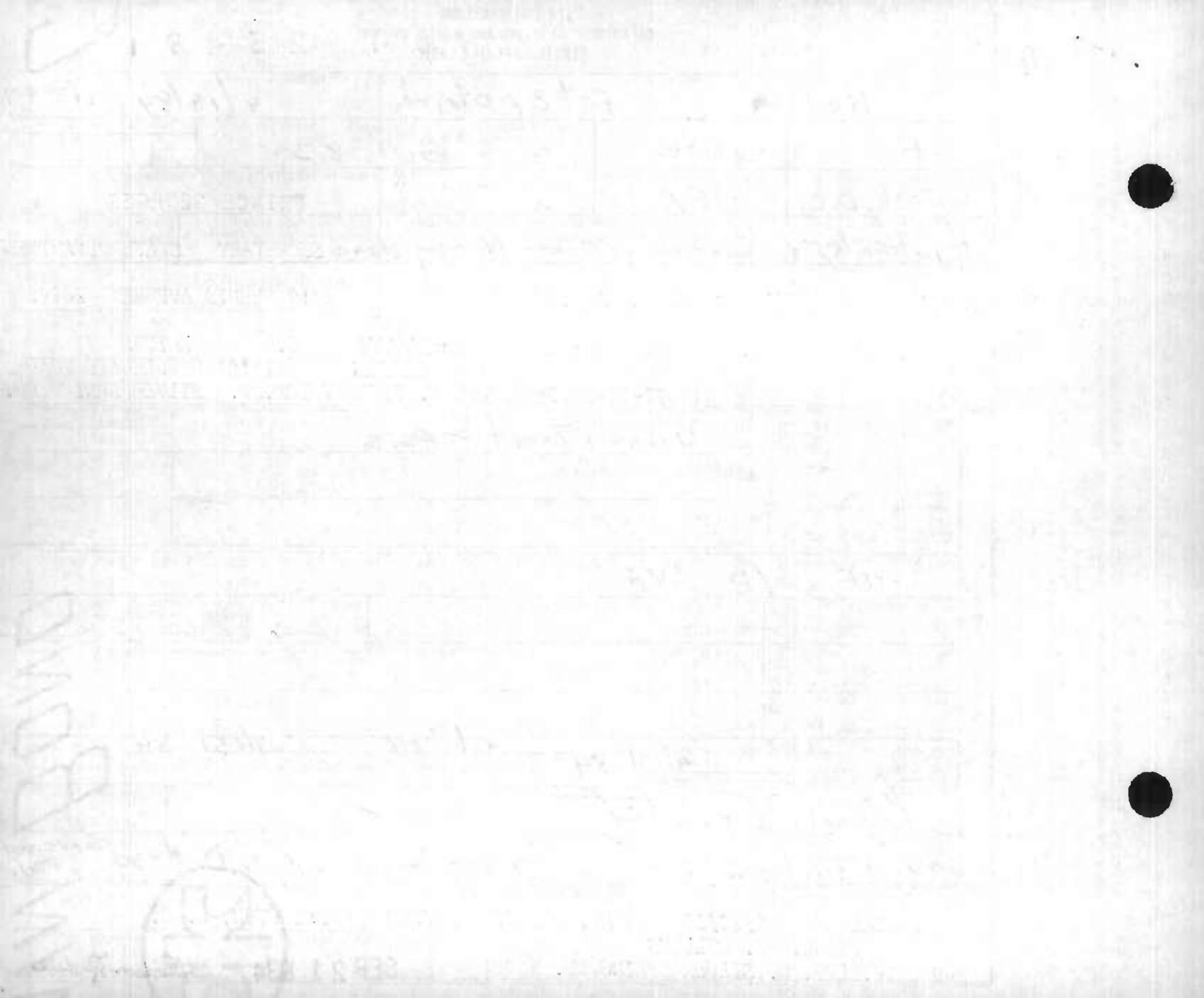
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified.

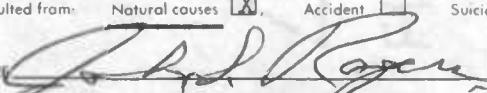
## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25491	REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
Helena c. Fitzpatrick						9/19/84			9	19	84	1100 AM				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE [IN YEARS LAST BIRTHDAY]			IF UNDER 1 YEAR		IF UNDER 24 HRS		
F			White			MONTH 3 DAY 4 YEAR 01			83			MONTHS		DAYS		
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			PRINCE GEORGES MD.				
Washington, D.C.			USA													
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			STATE DEPARTMENT				
Hyattsville			Carroll Manor Nursing Home			SECRETARY										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			4419 DENNIS AVENUE 20902	
MARYLAND			MONTGOMERY			SILVER SPRING										
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST	
JOSEPH			B.			FITZPATRICK			CHARLOTTE			C.			KNIBBS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			AD 15721 MIDDLEGATE ROAD			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO			577-32-6273			BROTHER			JOSEPH V. FITZPATRICK, SR.			SILVER SPRING, MD.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)]																
Ventricular Thromb Sepsis																
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																
(b) _____																
DUE TO, OR AS A CONSEQUENCE OF (c) _____																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CHF S/P CVA																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH [IF EITHER, NOTIFY MEDICAL EXAMINER]			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from 9/13/84 to 9/13/84, that (I) (we) last saw the deceased alive on 9/13/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we did) (did not) view the body after death.												22c. DATE SIGNED 4/1/84				
22d. PHYSICIAN'S NAME [TYPE OR PRINT] Stuart Turkel			22e. ADDRESS 7500 Greenway Caf. Dr. #430 Greenbelt Md.			DEGREE										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9/22/84			23c. NAME OF CEMETERY OR CREMATORIAL MT. OLIVET CEMETERY			23d. LOCATION CITY OR TOWN WASHINGTON, D. C.			COUNTY	STATE			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNTV. BLVD., W., SILVER SPRING, MD. 20901									25a. DATE REC'D. BY REGISTRAR SEP 21 1984			25b. REGISTRAR'S SIGNATURE Lisa Davidson-Randall				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 3 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 25492				
1- STATE REGISTRAR			LAST						2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR			2b. HOUR 9:10 A.M.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		IF UNDER 1 YR.		IF UNDER 24 HRS.							
William J. Fleming																
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		MONTHS		DAYS		HOURS MIN.				
Male		Black		Nov. 29, 1918		65										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD		2d. HOUR 9:10 A.M.				
Md.		U.S.A.								9/17 1984						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY				
Landover		3503 Hubbard Road, #303						Unemployed				None				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		20785						
Maryland		Prince Georges		Landover				3503 Hubbard Road, #303								
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST						
Robert				Fleming		Carrie				Snell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		(YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
Yes		WW II		220-05-9490		Rose Blachard-Palmer Pk., Md.		1803 Palmer Pk. Rd.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u> DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.  (b) DUE TO, OR AS A CONSEQUENCE OF																
(c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																
Chronic alcoholism.																
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												and in my opinion				
ACTUAL SIGNATURE 												TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER 1919 Seminary Road				
EXAMINED NAME (TYPE OR PRINT) John S. Rogers, M.D.												ADDRESS Silver Spring, Montgomery, Md.				
23a. BURIAL, CREMATION, REMOVAL			23b. DATE 9/22/84			23c. NAME OF CEMETERY OR CREMATORIAL HARMONY MEM. PARK			23d. LOCATION CITY OR TOWN HIGHLAND PARK P.G. 110.			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME H. S. WASHINGTON & SONS			ADDRESS 4925 BURROUGHS AV. N.E.			25a. DATE REC'D. BY REGISTRAR SFP 20 1984			25b. REGISTRAR SIGNATURE <i>John S. Rogers, M.D.</i>							
20M 4/B2		DHMH - 17 (VR A15 ME (5))														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 25493
1 - STATE REGISTRAR	2a. DATE OF DEATH MONTH DAY YEAR 9 26 84				2b. HOUR 12 15 AM
1. DECEASED NAME (TYPE OR PRINT) WILLIAM R. FLESHMAN	MIDDLE	LAST	2c. DATE RECEIVED BY REGISTRAR 09/26/84	2d. REGISTRAR'S SIGNATURE JANE DAVIDSON-RANDOL	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 7, 1909	6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE COUNTY MD.		
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver	12b. KIND OF BUSINESS OR INDUSTRY Dixie Plywood Co.		
13a. STATE Maryland	13b. COUNTY P.G.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 20740 9014 Rhode Island Ave. #307		
14. FATHER'S NAME FIRST John	MIDDLE C.	LAST Fleshman	15. MOTHER'S MAIDEN NAME Evie		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 212-14-5291	17. INFORMANT Mr. William J. Fleshman	ADDRESS 11723 Emack Road Beltsville, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHIOGENIC CARCINOMA				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b)					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a SEVERE COPD					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/25/84, 1984, to 9/25/1984, that (II) (we) last saw the deceased alive on 9/25/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (II) (we) did not view the body after death.					
22b. SIGNATURE GERARDO M GACAD MD		DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8/26/84	
22e. ADDRESS 6492 LANDOVER RD. LANDOVER MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sept. 29, 1984	23c. NAME OF CEMETERY OR CREMATOR Y Lakemont Mem. Gardens	23d. LOCATION CITY OR TOWN Cem. Davidsonville A.A. Md.	25b. REGISTRAR'S SIGNATURE JANE DAVIDSON-RANDOL	
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland	ADDRESS 101 Hyattsville	25a. DATE RECEIVED BY REGISTRAR 09/26/84			

silver

final answer 35.74

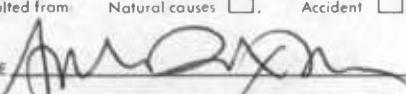
before adjustment because of the 10% increase

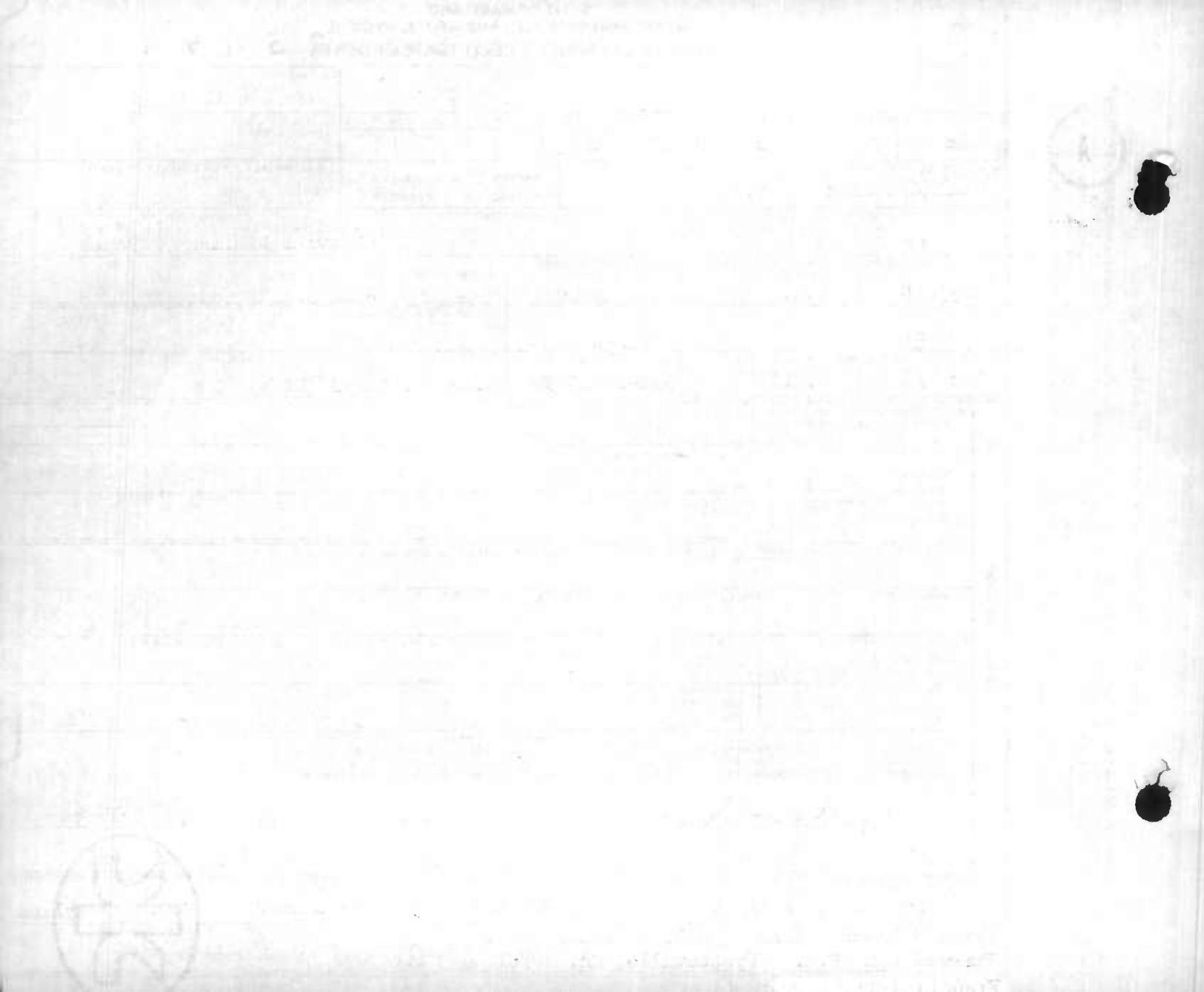
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR FILING. FORM PM SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1- STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH5 4 9 4  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST JOHN	MIDDLE Tally	LAST FLOYD, SR.	2a. DATE KNOWN OF EST. DEATH MATED	MONTH 9	DAY 15	YEAR 1984	2b. HOUR 6:29 p.m.	
3. SEX	4 RACE	S. DATE OF BIRTH MONTH DAY YEAR	5. AGE (IN YEARS LAST BIRTHDAY) 62 yrs.	6. IF UNDER 1 YR.	7. IF UNDER 24 HRS.						
Male	White	5 9 22		MONTHS	DAYS	HOURS	MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH	
South Carolina		U.S.A.								Prince George's County	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Brentwood		4504 38th St.			Service Lineman			Pepco			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland		P.G.		Brentwood		X		4504 38th Street 20722			
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST				
Frank			Floyd	Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO, OR UNKNOWN		(IF YES, GIVE WAR ORDERS)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Yes		W.W.II		558-36-5339		Alice M. Floyd (Wife)		Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head (unspecified weapon)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (e.g.)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							20. AUTOPSY? Head Only <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 9-15-1984			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Self-inflicted.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home			21f. LOCATION STREET 4504 38th St., Brentwood, Prince George's, Md. COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE 										TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.										DATE SIGNED 9-17-84	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 9/19/84			23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery			23d. LOCATION CITY OR TOWN Brentwood		
24. FUNERAL DIRECTOR NAME			ADDRESS Frantz Gasch's Sons 4739 Baltimore Ave.			25a. DATE REC'D. BY REGISTRAR SEP 20 1984			25b. REGISTRAR'S SIGNATURE Julie Davidson-Randall		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/transit period. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25495		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
HENRY (NMN)					FORSTER.	SEPT. 15. 1984						2-50 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		
Male		White		Oct. 1, 1904			79			YEARS	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Pr. Geo.				
Penn.		U.S.A.												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Riverdale		Leland Memorial Hosp.		Ret. construction worker			(20782)							
13a. STATE Md.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN West Hy.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 6305 - 23rd Avenue				
14. FATHER'S NAME FIRST Gustav		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST (Unknown)									LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN No		16b. SOCIAL SECURITY NO. - - -		17. INFORMANT 577-10-5735 Herbert G. Forster			ADDRESS Nob Hill Blackwood, N.J.							
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Squamous Cell Bronchogenic Carcinoma										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) metastasis to Bone & hypercalcemia												
		DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Heart failure												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
(1) ATHEROSCLEROTIC HEART DISEASE (2) PHIMOSIS AND STRICTURE OF URETHRA														
19a. DATE OF OPERATION 8/23/84.		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Needle Biopsy for carcinoma of lung		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED - - - NA			NA							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK NA		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.) NA		21f. LOCATION STREET NA			CITY OR TOWN NA			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 14 1984</u> to <u>Sept 15 1984</u> , that (I) (we) last saw the deceased alive on <u>Sept 14 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Rudapi, MD		22c. DEGREE MD		22d. DATE SIGNED Sept 15, 1984										
22e. PHYSICIAN'S NAME (TYPE OR PRINT) SHRINIVAS RUDAPI		22f. ADDRESS 6005 Landover Rd. CHEVERLY MD 20785												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9-17-84		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Crematory			23d. LOCATION CITY OR TOWN Brentwood			COUNTY Pr. Geo.		STATE Md.		
24. FUNERAL DIRECTOR Nalley's F.H. Inc. Mt. Rainier, Md.					25a. DATE REC'D. BY REGISTRAR SEP 21 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall						

A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner may be informed about it.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25496			
												REG. NO.			
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR			
CATHERINE G. FRABER						SEPTEMBER			23	1984	9:50 AM				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		CAUCASIAN		JUNE 17, 1920			64			YEARS	MONTHS	DAYS	HOURS	MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			PRINCE GEORGES COUNTY MD.					
NEW YORK		U.S.A.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
LAUREL		GREATER LAUREL BELTSVILLE HOSPITAL										HOMEMAKER			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a STATE		13b COUNTY		13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE					
MARYLAND		PRINCE GEO. LAUREL								13903 BRIARWOOD DRIVE 20807					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST					
		DANIEL	JAMES	WHELAN				HELEN	C.	CUNNINGHAM					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS								
NO		579-16-3648		DANIEL FRABER			SAME AS 13				SON				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (o) <i>Cardio pulmonary arrest</i>															
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertension</i>															
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last.															
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Nephrotic syndrome</i>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
										YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>9/1/77</i> , 19 <i>84</i> , to <i>9/23</i> , 19 <i>84</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>9/2/84</i> , 19 <i>84</i> , and that in <input checked="" type="checkbox"/> (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.															
22b. SIGNATURE <i>Ananthra</i>					DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/23/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ANANTHA K RAO</i>					22e. ADDRESS 7676 New Hampshire ave #40 Langley Park MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/27/84		23c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NATIONAL			23d. LOCATION CITY OR TOWN ARLINGTON		COUNTY		STATE VIRGINIA				
24 FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i> ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901								25a. DATE REC'D. BY REGISTRAR OCT 1 1984		25b. REGISTRAR'S SIGNATURE <i>Gilia Davidson-Bender</i>					

towne paragon abel

holmes

newark ohio u

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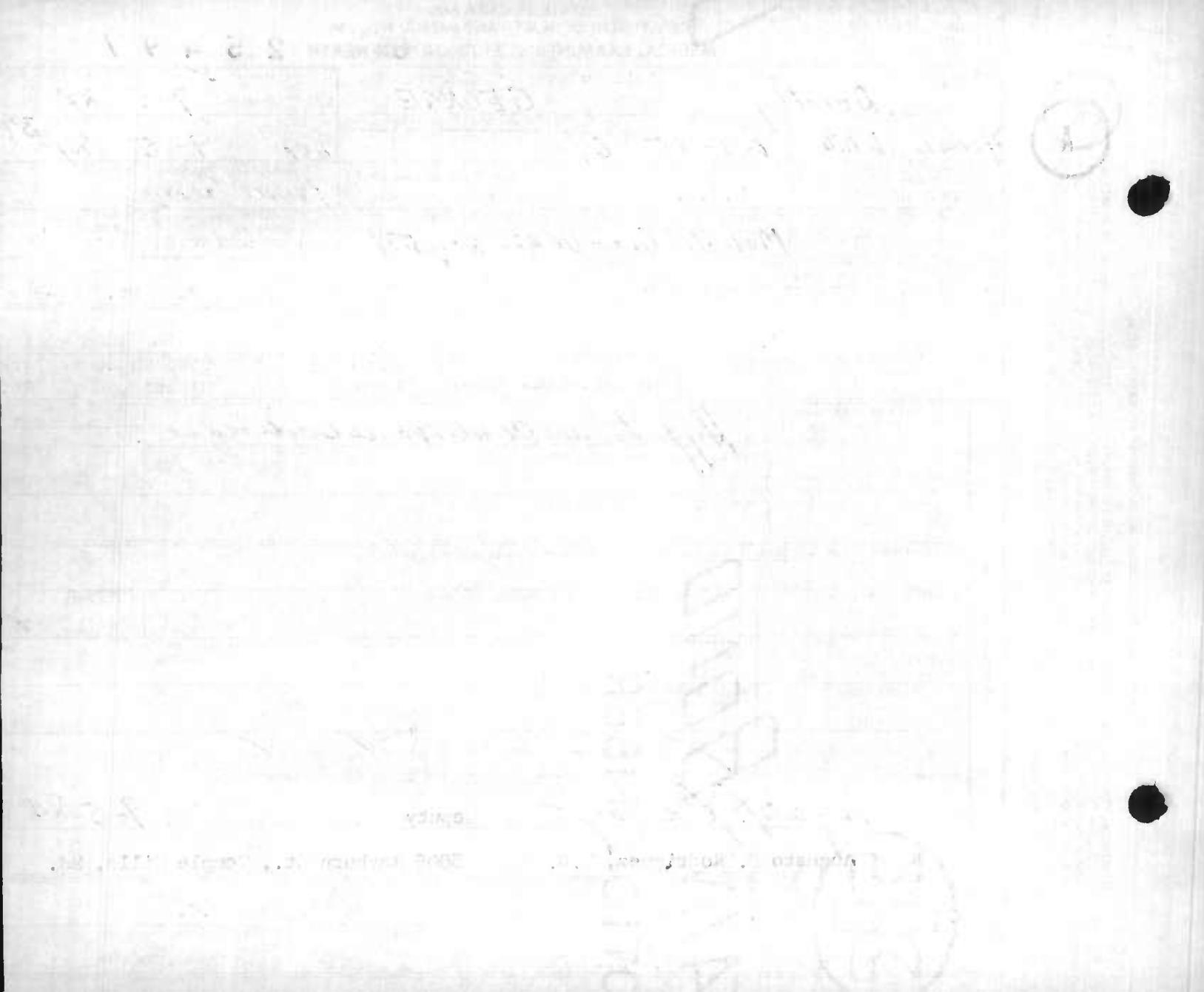
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 24 HOURS OF DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										25497	REC. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	Dorothy	MIDDLE	Genevieve	LAST	George	2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR	
<i>Dorothy</i>						<i>GEORGE</i>			<i>9-5 1984</i>			2d. HOUR	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.				2c. DATE PROMONOUNCED <i>9-5 1984</i>			2d. HOUR	
female	White	1-1-15	69 yrs.									2d. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			BALTIMORE CITY OR COUNTY OF DEATH			MD.	
North Dakota			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			<i>Prince George</i>				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Andrews AFB			Malcolm Gross US AF Hospital						Legal secretary			Legal	
13a. STATE Maryland			13b. COUNTY Prince Georges		13c. CITY OR TOWN Ritchie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9526 Chestnut Park St./20743				
14. FATHER'S NAME FIRST			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
Ernest			C.		Johnson		Christina				Nordlund		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. 09-3804			17. INFORMANT (friend) Kermit Sherman			ADDRESS 9526 Chestnut Park Ritchie, MD St.				
No			502-12-0319										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (_____ DUE TO, OR AS A CONSEQUENCE OF <i>Hypertension and cardiovascular disease.</i>													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?				
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. * 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>													TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.													DATE SIGNED <i>9-5-84</i>
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Sept. 7, 1984			23c. NAME OF CEMETERY OR CREMATORY Lee Crematory			23d. LOCATION CITY OR TOWN Washington, D.C.			STATE	
24. FUNERAL DIRECTOR NAME			ADDRESS						25a. DATE REC'D. BY REGISTRAR EP 11 1984			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	
Capitol Funeral Service, Falls Church, VA													



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IRVIN ALLEN GOEBEL MEDICAL EXAMINER'S CERTIFICATE OF DEATH 25498 REC NO. 25498																	
1- FOR STATE REGISTRAR			1. DECEASED NAME FIRST MIDDLE LAST <i>IRVIN Arthur Goebel</i>														
2a. DATE KNOWN OF ESTI- DEATH MATED			2b. MONTH DAY YEAR <i>Sep 27 1984</i>			2d. HOUR <i>4:00 P.M.</i>											
2c. DATE PRONOUNCED DEAD			2d. MONTH DAY YEAR <i>Sep 27 1984</i>			2e. HOUR <i>4:00 P.M.</i>											
3a. SEX <i>M</i>			3b. RACE <i>White</i>			3c. DATE OF BIRTH MONTH DAY YEAR <i>Jan 27 1912 72 yrs</i>			3d. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. <i>72 yrs</i>								
3e. BIRTHPLACE STATE OR FOREIGN COUNTRY <i>Washington D.C.</i>			3f. CITIZEN OF WHAT COUNTRY <i>USA</i>			3g. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			3h. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George's Co. MD.</i>								
3i. CITY OR TOWN OF DEATH <i>Suburb</i>			3j. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Federal Center Beltsville Hospital Suburban Trust</i>														
3k. USUAL RESIDENCE (IF IN HOSPITAL HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>Suburb</i>			3l. STATE <i>Maryland</i>			3m. COUNTY <i>Baltimore County</i>			3n. CITY OR TOWN <i>Bethesda</i>								
3o. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			3p. STREET ADDRESS <i>14524 Dowling Dr.</i>			3q. USUAL OCCUPATION (TYPE OF WORK) FOR INDIVIDUAL WORKING (IF ANY) <i>Retired Suburban Trust</i>			3r. KIND OF BUSINESS OR INDUSTRY <i>None</i>								
3s. FATHER'S NAME FIRST MIDDLE LAST <i>FRANCES E. Goebel</i>			3t. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>LOUISE Guenel</i>			3u. SOCIAL SECURITY NO. <i>217-16-0084</i>											
3v. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input checked="" type="checkbox"/> YES			3w. PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anemia myocardial disease</i>			3x. DUE TO, OR AS A CONSEQUENCE OF <i>Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.</i>			3y. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>None</i>								
3z. (b) DUE TO, OR AS A CONSEQUENCE OF <i>None</i>			3aa. (c) DUE TO, OR AS A CONSEQUENCE OF <i>None</i>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1-a: <i>None</i>																	
3bb. DATE OF OPERATION <i>None</i>			3cc. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>None</i>									3dd. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
3ee. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			3ff. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			3gg. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>None</i>											
3hh. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			3ii. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>None</i>			3jj. LOCATION STREET <i>None</i>			3kk. CITY OR TOWN <i>None</i>			3ll. COUNTY <i>None</i>			3mm. STATE <i>None</i>		
3nn. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
3oo. ACTUAL SIGNATURE <i>John R. Rogers, M.D.</i>												3pp. TITLE (SPECIFY) <i>Medical Examiner</i>			3qq. DATE SIGNED <i>Sep 27 1984</i>		
3rr. EXAMINER'S NAME (TYPE OR PRINT) <i>John R. Rogers</i>												3ss. ADDRESS <i>None</i>					
3tt. BURIAL, Cremation, Removal DATE <i>Burial Oct 1 1984</i>			3uu. NAME OF CEMETERY OR CREMATORIAL <i>Takoma Funeral Home</i>			3vv. LOCATION CITY OR TOWN <i>Takoma Park, Montgomery Co., Md.</i>											
3ww. FUNERAL DIRECTOR NAME <i>Julie Davidson-Pender</i>			3xx. ADDRESS <i>254 Carroll St. N.W. Washington, D.C. 20008</i>			3yy. DATE REC'D. BY REGISTRAR <i>Oct 1 1984</i>			3zz. REGISTRAR'S SIGNATURE <i>Julie Davidson-Pender</i>								

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DHMH-17  
(VR A15 ME (5))  
15M 2/80

2751

and the 1000' elevation

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon separator, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury or other traumatic event, the medical certificate must be completed and attached to this page.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25499
												REG. NO.
1. DECEASED NAME <b>A/R/A Agnes Lorraine Goldsmith</b> <b>Lorraine Middleton Goldsmith</b>												2. DATE OF DEATH MONTH DAY HOUR <b>9 10 84 10 05 AM</b>
3. SEX <b>Female</b>		4. RACE <b>Cau.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 26, 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73 yrs</b>		7. IF UNDER 1 YEAR MONTH DAYS HOURS MIN. <b> </b>				
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's MD.</b>						
12. CITY OR TOWN OF DEATH <b>Clinton</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Md. Hosp. Center</b>		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Med. Records Clerk</b>		15. KIND OF BUSINESS OR INDUSTRY <b>D. C. Gov't.</b>						
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17. STATE <b>Maryland</b>		18. COUNTY <b>Charles</b>		19. CITY OR TOWN <b>Waldorf</b>		20. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. STREET ADDRESS / ZIP CODE <b>Highway 925 North Box 152 20601</b>				
22. FATHER'S NAME FIRST <b>Alexis</b>		MIDDLE <b>L.</b>		LAST <b>Middleton</b>		23. MOTHER'S MAIDEN NAME FIRST <b>Mary</b>		MIDDLE <b>Jane</b>		LAST <b>Martin</b>		
24. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		25. SOCIAL SECURITY NO. <b>220-41-9857</b>		26. INFORMANT <b>Teresa Boyle</b>		27. ADDRESS <b>Box 1270 Waldorf, Md.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
28. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a):  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:  DUE TO, OR AS A CONSEQUENCE OF (b):  DUE TO, OR AS A CONSEQUENCE OF (c):  PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.  <b>Cardiopulmonary Arrest</b> <b>Hepatic Failure &amp; Coma</b> <b>Nephro - Renal Syndrome</b>												
29. DATE OF OPERATION		30. CONDITION FOR WHICH OPERATION WAS PERFORMED				31. AUTOPSY?		32. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
33. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		34. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		35. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 34, PART 1 OR PART 2)		36. LOCATION STREET		37. CITY OR TOWN		38. COUNTY		
39. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		40. PLACE OF INJURY FAT HOME, STREET, FACTORY, OFFICE, FARM, ETC.		41. LOCATION STREET		42. CITY OR TOWN		43. COUNTY		44. STATE		
45. I certify that (I) (this hospital) attended the deceased from <b>19/10/84</b> to <b>19/10/84</b> , that (I) (we) last saw the deceased alive on <b>19/10/84</b> . (b) (we) did not witness the death. (c) (we) did not view the body after death.												
46. SIGNATURE <b>Jack H. Hudson, M.D.</b>		47. DEGREE <b>ATTENDING PHYSICIAN</b>		48. MEDICAL STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		49. DATE SIGNED <b>9/10/84</b>						
50. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jack H. Hudson</b>		51. ADDRESS <b>9015 Woodyard Road, #201 Clinton, Maryland 20735</b>		52. LOCATION CITY OR TOWN <b>Waldorf, Charles, Md.</b>		53. COUNTY <b>Charles</b>						
54. BURIAL, CREMATION, REMOVAL LINES 51-52 <b>Burial</b>		55. DATE <b>9-13-84</b>		56. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>St. Peter's Cem. Hunt Funeral Home, Waldorf, Md.</b>		57. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE <b>SEP 13 1984 John Hudson-Randall</b>						
58. FUNERAL DIRECTOR NAME <b>Huntt Funeral Home</b>		59. ADDRESS <b>Waldorf, Charles, Md.</b>										
DHMH - 16 50M 4/83 (VRA 15, 4)												

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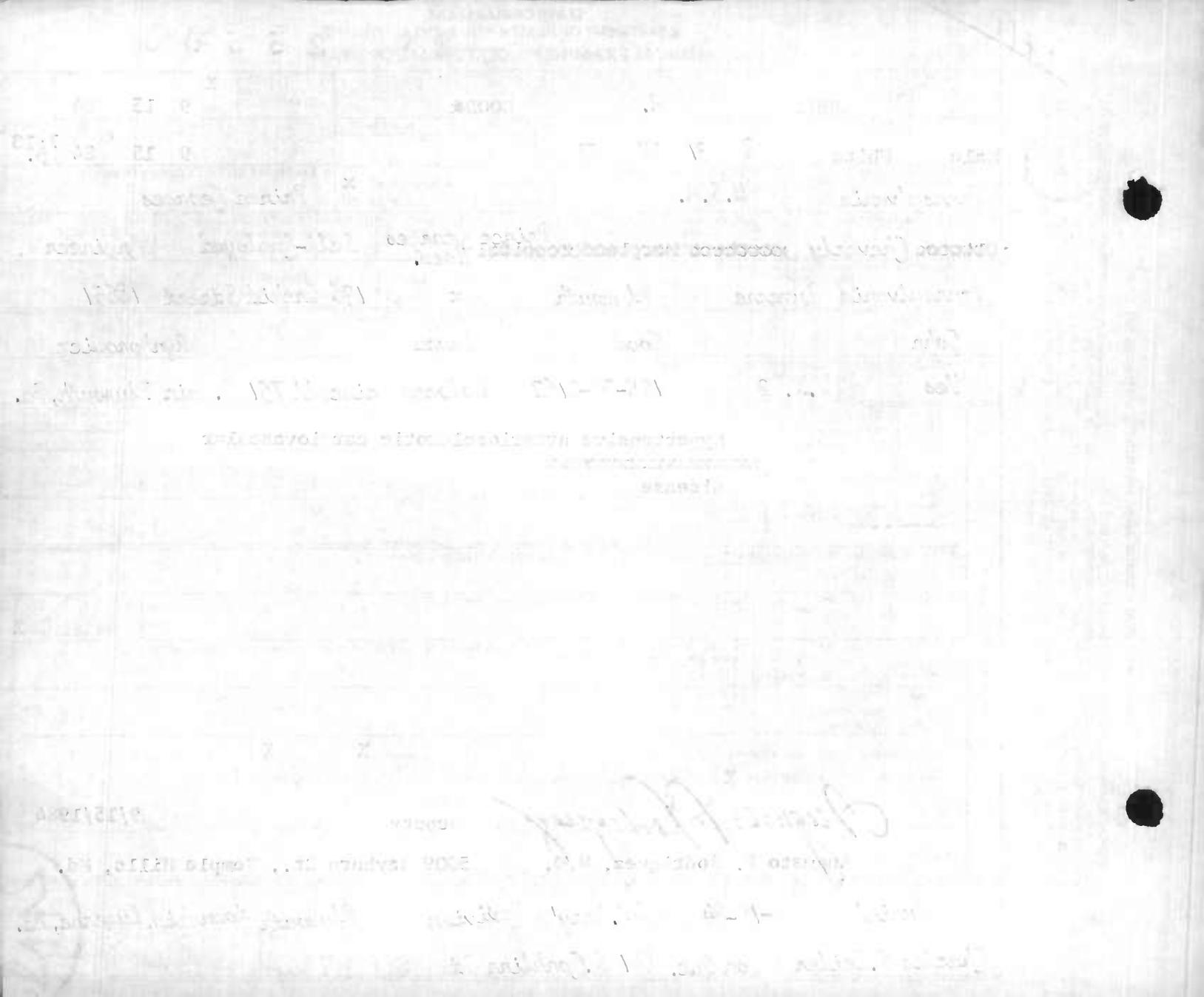
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5 5 0 0  
REG. NO.

1. STATE REGISTRAR		2. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>9 15 1984</b>													
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE			LAST						2b. HOUR	
<b>JOHN</b>		<b>A.</b>			<b>GOOD</b>										
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.			IF UNDER 1 yr. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD <b>9 15 1984</b>	
<b>Male</b>		<b>White</b>		<b>8 31 27</b>										MONTH DAY YEAR <b>p.m.</b>	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?												9. BALTIMORE CITY OR COUNTY OF DEATH	
<b>Pennsylvania</b>		<b>U.S.A.</b>												<b>Prince Georges</b>	
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
<b>Clinton Cheverly</b>		<b>Prince Georges Hospt.</b>												<b>Self-Employed</b>	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			12b. KIND OF BUSINESS OR INDUSTRY		
<b>Pennsylvania</b>		<b>Luzerne</b>		<b>Plymouth</b>						<b>196 Orchid Street 18651</b>			<b>Engineer</b>		
14. FATHER'S NAME		MIDDLE			LAST			15. MOTHER'S MAIDEN NAME							
<b>John</b>					<b>Good</b>			<b>Laura</b>						<b>Rynkorowicz</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
<b>Yes</b>		<b>W.W. 2</b>			<b>195-20-2162</b>			<b>Dolores Driscoll</b>			<b>751 W. Main Plymouth, Pa.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive arteriosclerotic cardiovascular</b> Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause lost. (b) <b>disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?	
														YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) <b>M.D.</b>			Deputy			MEDICAL EXAMINER			DATE SIGNED <b>9/15/1984</b>				
EXAMINER'S NAME (TYPE OR PRINT)		<b>Augusto P. Rodriguez, M.D.</b>			ADDRESS <b>5009 Rayburn Ct., Temple Hills, Md.</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <b>Burial 9-19-84</b>			23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Nativity</b>			23d. LOCATION CITY OR TOWN <b>Plymouth township, Luzerne, Pa.</b>							
24. FUNERAL DIRECTOR NAME		ADDRESS						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
<b>Charles S. Zeiler &amp; Son Inc.</b>		<b>901 S. Conkling St.</b>						<b>SEP 17 1984</b>			<b>Julia Davidson-Randall</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in b (the funeral director, page 3) should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

## MEDICAL CERTIFICATION

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

25501

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>FRED LAWRENCE GOODSPED, SR.</b>	MIDDLE	LAST	2a. DATE OF DEATH <b>Sep 29 84</b>	MONTH	DAY	YEAR	2b. HOUR <b>0450 a.m.</b>	
3. SEX <b>Male</b>			4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 3 1920</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>64 YRS.</b>	IF UNDER 1 YEAR <b>MONTHS</b>	IF UNDER 24 HRS. <b>DAYS</b>	IF UNDER 24 HRS. <b>HOURS MIN.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Oklahoma</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's MD.</b>					
10. CITY OR TOWN OF DEATH <b>Andrews Air F.B. Camp Springs</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Malcolm Graw Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>U.S.A.F.-Retired</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Military</b>			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Prince George Oxon Hill</b>		13c. CITY OR TOWN <b>Prince George Oxon Hill</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>6275 Oxon Hill Rd. #302 20745</b>		
14. FATHER'S NAME FIRST <b>Charles</b>			MIDDLE <b>J.</b>	LAST <b>Goodspeed</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Hazel</b>		MIDDLE <b>Mae</b>	LAST <b>Keesler</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII - Korea 443-09-2736</b>		17. INFORMANT <b>Patricia Goodspeed</b>			ADDRESS <b>6275 Oxon Hill Rd. Oxon Hill, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____			18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u>		18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY arrest</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic CA of lung</u>		DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic CA of lung</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) above (if any) did not view the body after death.						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (1) this hospital attended the deceased from <u>28 Sept</u> , 19 <u>84</u> , to <u>29 Sept</u> , 19 <u>84</u> , that (2) (was last seen the deceased alive on <u>29 Sept</u> , 19 <u>84</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If <input type="checkbox"/> did not view the body after death.)											
22b. SIGNATURE <u>Timothy Y. Chou</u>			22c. DEGREE		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <u>29 Sep 84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Timothy Y. Chou MD.</b>			22e. ADDRESS <b>Malcolm Graw Medical Center Andrews Air Force Base, Maryland</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10/2/84</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington Nat'l. Cem.</b>		23d. LOCATION CITY OR TOWN <b>Arlington</b>		COUNTY	STATE	
24. FUNERAL DIRECTOR NAME <b>George P. Kalas Funeral Home Oxon Hill, Md.</b>			25a. ADDRESS <b>6160 Oxon Hill Rd.</b>		25b. DATE REC'D. BY REGISTRAR <b>OCT 2 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Jude Davidson-Kendall</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 3425502
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
MARGARET M. Gough					Gough			September 24, 1984				2:17A M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		MONTH	DAY	YEAR	86	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Connecticut		U.S.A.					Prince George's					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR COLLEGE					
Hyattsville		2015 Powhatan Rd.		Retired Housemother			St. Joseph's					
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
Md.		P.G.		Hyattsville			2015 Powhatan Rd. 20782					
14. FATHER'S NAME		FIRST	MIDDLE	15. MOTHER'S MAIDEN NAME			16. ADDRESS					
Declan			Welch	Margaret			2015 Powhatan Road					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					
No		578 56 6844		Rita G. Emmell			Hyattsville, Md. 20782					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Metastatic carcinoma										1979
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost.		(b) Carcinoma of breast										1977
19. DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)										
20. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to Sept 24, 1984, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Raymond Bradshaw, MD.				DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Raymond Bradshaw, MD							22e. ADDRESS 345 University Blvd., West, Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/28.84		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. Bernards			23d. LOCATION CITY OR TOWN Rockville Conn.		COUNTY		STATE	
24. FUNERAL DIRECTOR Francis Gasch's Sons F.H. P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781							25. SIGNED AND FILED BY REGISTRAR OR REGISTERAR'S SIGNATURE SEP 28 1984 John Dawson Pendleton					

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25503  
REG. NO.

1- STATE REGISTRAR																					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- MATED		MONTH	DAY	YEAR	2b HOUR				
Angelia L. GRAHAM												<input type="checkbox"/>					9-22 1984				
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d HOUR	
Female		Black		4-12-70		14 yrs.		MONTHS		DAYS		HOURS		<input type="checkbox"/>		9-22		1984		11:50 AM	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD									
8a CITY OR TOWN OF DEATH			8b. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			Fort Washington			11. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			Student			12b. KIND OF BUSINESS OR INDUSTRY						
Fort Washington			7118 Crafford Place												School			20744			
13a. STATE			13b. COUNTY			14. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			12b. KIND OF BUSINESS OR INDUSTRY						
Maryland			P.G.			Fort. Wash.			<input checked="" type="checkbox"/>			7218 Crafford Place.						20744			
14. FATHER'S NAME			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME												
Landrum			S.			Graham Jr.			Gracie			M.			Allen						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS												
No			None			Landrum S. Graham Jr. SAA															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Epithelial carcinoma, metastatic</i> DUETO, OR AS A CONSEQUENCE OF																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u> (b) DUETO, OR AS A CONSEQUENCE OF (c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?												
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			20. AUTOPSY?												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>			EXAMINER'S NAME (TYPE OR PRINT)			Augusto P. Rodriguez, M.D.			TITLE (SPECIFY) Deputy M.D.			MEDICAL EXAMINER			DATE SIGNED 9-22-84						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY			STATE						
Burial			9-26-84			Lincoln Mem. Cem.			Suitland			P.G. MD									
24. FUNERAL DIRECTOR NAME			ADDRESS			ADDITIONAL INFORMATION			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
ADAMS F.H.PA			AQUASCO MD 20608			OCT 01 1984															

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3 RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT; PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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and the associated

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. If page 3 and 2 are used together within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical certifying physician must initial and date this block.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25504						
										REG. NO.						
1. FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR						
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		September 30, 1984 7:42 A.M.							
Clifton			E.		W.M.		Graham									
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			White			February 26, 1889			95			MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland			USA						Prince George's							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Laurel			Greater Laurel Beltsville Hospital carpenter										construction			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
Md			PG		Beltsville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			4005 Foreston Road 20705					
14. FATHER'S NAME			FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME							
Joseph							Graham		FIRST Miranda			MIDDLE Chaney LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
no			218 20 2060-01			Lois Harris same as above										
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 HOURS</u>						
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>INTRACTABLE CONGESTIVE HEART FAILURE</u>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
										YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 21b PART I OR PART II)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET				CITY OR TOWN		COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Sept 24 1984 Oct 19 82 to 10 82, 1984, and that in (my) our opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death.										22b. DATE SIGNED <u>9/30/84</u>						
22c. SIGNATURE <u>Chukwu My</u>			22d. DEGREE			22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ESMA CHADDO</u>			22g. ADDRESS <u>321 PRINCE GEORGE ST</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 2, 1984			23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Memorial Park				23d. LOCATION CITY OR TOWN Dorsey, Md		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Md			ADDRESS ADDRESS			25a. DATE RECEIVED BY REGISTRAR 8/30/84				25b. REGISTRAR'S SIGNATURE <u>Jean Davidson-Pendleton</u>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the name of director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Please send 2 sheets of paper within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 23 is marked on Item 18 under any injury, or other traumatic event, the medical examiner will be informed and advised.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 25505			
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR September 3 1984							2b. HOUR 2:40AM			
I. DECEASED NAME FIRST MIDDLE LAST Hugh Gray			5. DATE OF BIRTH MONTH DAY YEAR April 21, 1967			6. AGE (IN YEARS LAST BIRTHDAY) 17 YRS.			IF UNDER 1 YEAR MONTHS DAYS				
3. SEX Male			4. RACE Black			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County, MD.			IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Guyana			7b. CITIZEN OF WHAT COUNTRY? Guyana										
10. CITY OR TOWN OF DEATH Mt. Rainier			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4509 22nd Avenue			12a. USUAL OCCUPATION Student			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Md.			13b. COUNTY Prince Georges			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 4509 22nd Ave. / 20712				
14. FATHER'S NAME FIRST MIDDLE LAST Hugh R. D. Gray			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janette Raghunandan										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No			16b. SOCIAL SECURITY NO. None			17. INFORMANT Keith Wilson/4509 22nd. Ave. Mt. Rainier,			ADDRESS Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Osteosarcoma of the Right Femur (4-84) 5 mos.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) <input type="checkbox"/> attended the deceased from July 17, 1984, to September 3, 1984, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on August 30, 1984, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Albert E. Rolle, M.D.			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			DATE SIGNED Sept. 3 1984				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert E. Rolle, M.D.			22e. ADDRESS 3800 Reservoir Rd., N.W., Wash, D.C.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/6/84			23c. NAME OF CEMETERY OR CREMATORIAL Harmony Mem. Park			23d. LOCATION CITY OR TOWN Landover COUNTY P.G. STATE Md.				
24. FUNERAL DIRECTOR Sam Butler Inc.			NAME ADDRESS 716 Kennedy St. N. W., D. C.			25a. DATE REC'D. BY REGISTRAR SEP. 10, 1984			25b. REGISTRAR'S SIGNATURE				

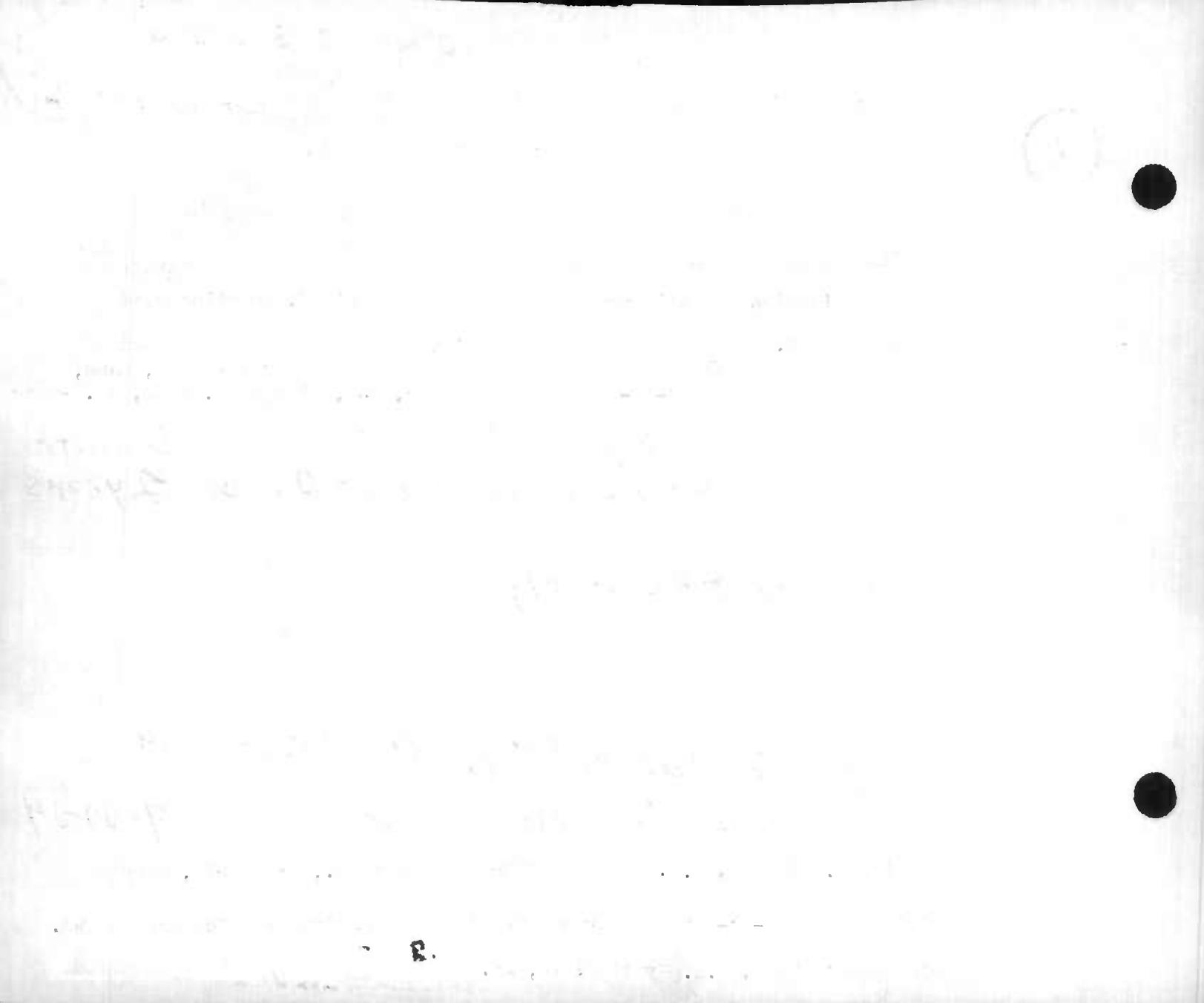


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						25506
						REG. NO.
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH DAY YEAR
I. DECEASED NAME (TYPE OR PRINT)			LAST			2b. HOUR
Ruth Culver Gray						Sept. 22 1984 9:48 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)
Female		White		MONTH DAY YEAR April 2, 1900		84
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland		U.S.A.				Prince George's MD.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
College Pk. Woods		9018 Gettysburg Lane				Teller
13a. STATE Md.		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		12b. KIND OF BUSINESS OR INDUSTRY Bank
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME		
Stanford C. Culver				Elizabeth		Nicholson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		9018 Gettysburg, Lane, Thomas Gray, Son, College Pk. Woods, Md. 20740
No		214-10-6215				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Myocardial Infarction				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediat
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease				2 years
(c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
					<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from <u>21 Sept 84</u> to <u>22 Sept 84</u> , that (1) (we) last saw the deceased alive on <u>21 Sept 84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.						
22b. SIGNATURE <u>William A. Wimsatt</u>		DEGREE M		22c. DATE SIGNED 9-22-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William A. Wimsatt, M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS 8150 Lakecrest Dr., Greenbelt, Maryland		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-26-1984		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION CITY OR TOWN Salisbury County STATE Wicomico Md.
24. FUNERAL DIRECTOR NAME ADDRESS Francis Gasch's Sons, P.A. Hyattsville, Md.						
25. DEATH REGISTRATION SIGNATURE SEP 27 1984 Julie Davidson-Pendell						



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 25507					
1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED <input type="checkbox"/> 9 3 1984		2b. HOUR M 7:45 PM			
		GEORGE B. GREEN															
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 3 1984		2d. HOUR M 7:45 PM	
Male		Cauc.		Jan. 22, 1906			78 yrs.										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.							
Minnesota		U.S.A.															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) I-95 So., near 295				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Col.				12b. KIND OF BUSINESS OR INDUSTRY U.S.A.F.							
13a. STATE Va.		13c. COUNTY Arlington		n/a		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2716 N. Nelson Street									
14. FATHER'S NAME First Edward		MIDDLE Baker		LAST Green		15. MOTHER'S MAIDEN NAME First Marie		Middle Annette		Last Lindholm							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1940-1961		17. INFORMANT Janet Green-2716 N. Nelson St. Arl, Va.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  8147      IMMEDIATE CAUSE (a) <u>Multiple injuries</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 6:50P.M. 9-3- 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Pedestrian struck by auto.													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET I-95 So. near 295		CITY OR TOWN		COUNTY Prince George's, MD.		STATE							
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Actual Signature <u>Dennis F. Smyth, M.D.</u> Assistant Title Specified MEDICAL EXAMINER												DATE SIGNED 9-4-84					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-6-84		23c. NAME OF CEMETERY OR CREMATORIAL Arl. National Cemetery		23d. LOCATION CITY OR TOWN Arlington, Va.		COUNTY		STATE							
24. FUNERAL DIRECTOR NAME Arlington Funeral Home-Arlington, Virginia		ADDRESS				25a. DATE REC'D. BY REGISTRAR SEP 11 1984		25b. REGISTRAR'S SIGNATURE <u>Jeanne Davidson-Pendell</u>									
BP																	
DHMH - 17 (VR A15 ME (5)) 20M 4/B2																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do my the favor of filling in the following information: (1) Name of deceased (2) Date of death (3) Place of death (4) Name of physician (5) Signature of physician  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 18 shows only injury, or other traumatic event, the medical certification section should be detached from the rest of the certificate.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 4										25508 REG. NO.		
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		9-13-84			12:28AM		
FRANKIE			V	GRIFFIN								
3. SEX Female			4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
					Feb. 27 1926		58 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.			7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.					
10. CITY OR TOWN OF DEATH CLINTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Checkout Clerk		12b. KIND OF BUSINESS OR INDUSTRY Food Chain					
13. STATE Maryland			13b. COUNTY P.G.		13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9550 Rhode Island 20740			
14. FATHER'S NAME FIRST Franklin			MIDDLE R.		LAST Howell		15. MOTHER'S MAIDEN NAME Elma		MIDDLE Vaughan		LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 414 38 9724		17. INFORMANT Delta Howell-Highway 125 South, Bolivar, Tenn.		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			Cancer of the Stomach.		Obstruction.		Cancer - rapidly fatal.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED - - -		21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 6-12 19 84		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE C. Montanez M.D.		22c. DATE SIGNED 6-15 1984		22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Montanez M.D.		22e. ADDRESS 330 P Dodge PK Rd (Brentwood, NC)			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 16, 1984		23c. NAME OF CEMETERY OR CREMATORIAL Walnut Grove Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. REGISTRAR'S SIGNATURE John Davidson Pendall			
24. FUNERAL DIRECTOR NAME Ives-Pearson F. Homes Arlington, VA. 22201			25a. DATE REC'D. BY REGISTRAR SEP 21		25b. REGISTRAR'S SIGNATURE							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Section 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25509			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
THOMAS C.					GRiffin ,JR	AUGUST 25 1984						2:00 AM	
3. SEX			4. RACE		5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE			BLACK		January 30, 1943	41			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8	YRS.			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
ANDREWS AFB			u.s.a		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	XXX			PRINCE GEORGE				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY					
ANDREWS AFB			MALCOLM GROW HOSPITAL		AIR FORCE, MILITARY, RETIRED			69990					
13a. STATE ILLINOIS			13b. COUNTY		13c. CITY OR TOWN LAMPVILLE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 3154 South Chanute Dr. 61866		
14. FATHER'S NAME FIRST unk			MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST unk			MIDDLE			LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 6/1961-6/1981 100-26-7995		17. INFORMANT Malcolm Grow Hospital Records, Andrews AFB, Md			ADDRESS					
18. CAUSE OF DEATH PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			CARDIOPULMONARY ARREST CARDIOPULMONARY ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost			DUE TO, CONGESTIVE HEART FAILURE/RENAL FAILURE CONGESTIVE HEART FAILURE/RENAL FAILURE										
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 24 AUG 1984, to 25 AUG 1984, that (I) (we) last saw the deceased alive on 25 AUG 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 25 AUG 84	
22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS DAVID TIPTON M.D., MALCOLM GROW HOSPITAL, ANDREWS AFB, MARYLAND										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Sept. 18, 1984			23c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NAT. CEMETERY, ARLINGTON, VIRGINIA			23d. LOCATION CITY OR TOWN			COUNTY	STATE
BURIAL													
24. FUNERAL DIRECTOR NAME LEE FUNERAL HOME, Clinton, Maryland 20735						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 20 1984							

P.S. 444 25

> 141 West?

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGE 1, 2, AND TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES NAMO 2 SHOULD BE SERVED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												5 5 1 0	REG. NO.												
1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2e. DATE KNOWN OF DEATH ESTIMATED		MONTH	DAY	YEAR	2b. HOUR						
		THELMA			S.						GROOMS			<input checked="" type="checkbox"/>					12:30						
		3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		9. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR						
		Female	Black	MARCH 25 1930			54 yrs.							<input checked="" type="checkbox"/>		9	04	1984	12:30						
		10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. NEVER MARRIED DIVORCED		10. BALTIMORE CITY OR COUNTY OF DEATH			11. DATE KNOWN OF DEATH ESTIMATED		MONTH	DAY	YEAR	2d. HOUR				
		VIRGINIA			U.S.A.			<input checked="" type="checkbox"/>			<input type="checkbox"/>		PRINCE GEORGES			<input checked="" type="checkbox"/>		9	04	1984	12:30				
		12. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13. DATE KNOWN OF DEATH ESTIMATED		MONTH	DAY	YEAR	2d. HOUR						
		Cheverly			Prince George's General Hospital			13a. STATE MARYLAND			13b. COUNTY PRINCE GEORGE			13c. CITY OR TOWN CAPITOL HEIGHTS			<input checked="" type="checkbox"/>		4804 ADDISON RD # 204	20743		EDUCATION			
		14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		GEORGE SAUNDERS									MARIA			NO			227-42-4801			CARL GROOMS 4804 ADDISON RD CAPT HEIGHTS		PART 1 DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		Rheumatic heart disease	
																						DUE TO, OR AS A CONSEQUENCE OF  (b) DUE TO, OR AS A CONSEQUENCE OF  (c)			
		19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
MEDICAL CERTIFICATION		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			21g. CITY OR TOWN			21h. COUNTY			21i. STATE								
		22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/>																				
		ACTUAL SIGNATURE <i>Augusto P. Rodriguez, M.D.</i>			EXAMINER'S NAME (TYPE OR PRINT)			EXAMINER'S ADDRESS 5009 Rayburn Ct., Temple Hills, Md.			TITLE (SPECIFY) Deputy			MEDICAL EXAMINER			DATE SIGNED								
		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 9/8/84			23c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN CEMETERY			23d. LOCATION CITY OR TOWN BRENTWOOD MARYLAND			23e. COUNTY MARYLAND			24. FUNERAL DIRECTOR NAME J.B. JENIKINS FUNERAL HOME 7474 LANDOVER RD		25a. DATE REC'D. BY REGISTRAR SEP 10 1984		25b. REGISTRAR'S SIGNATURE <i>Davidson Pendell</i>				
BP		DHMH - 17 (VR A15 ME (5)) 20M 4/82																							

as. No.

200000

NAME:

as. an.

asif sifaw

Initial "Initial" starting point: 200000

Search area code:

SEARCH

SEARCH

Initial search, starting point: 200000, count down 030000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

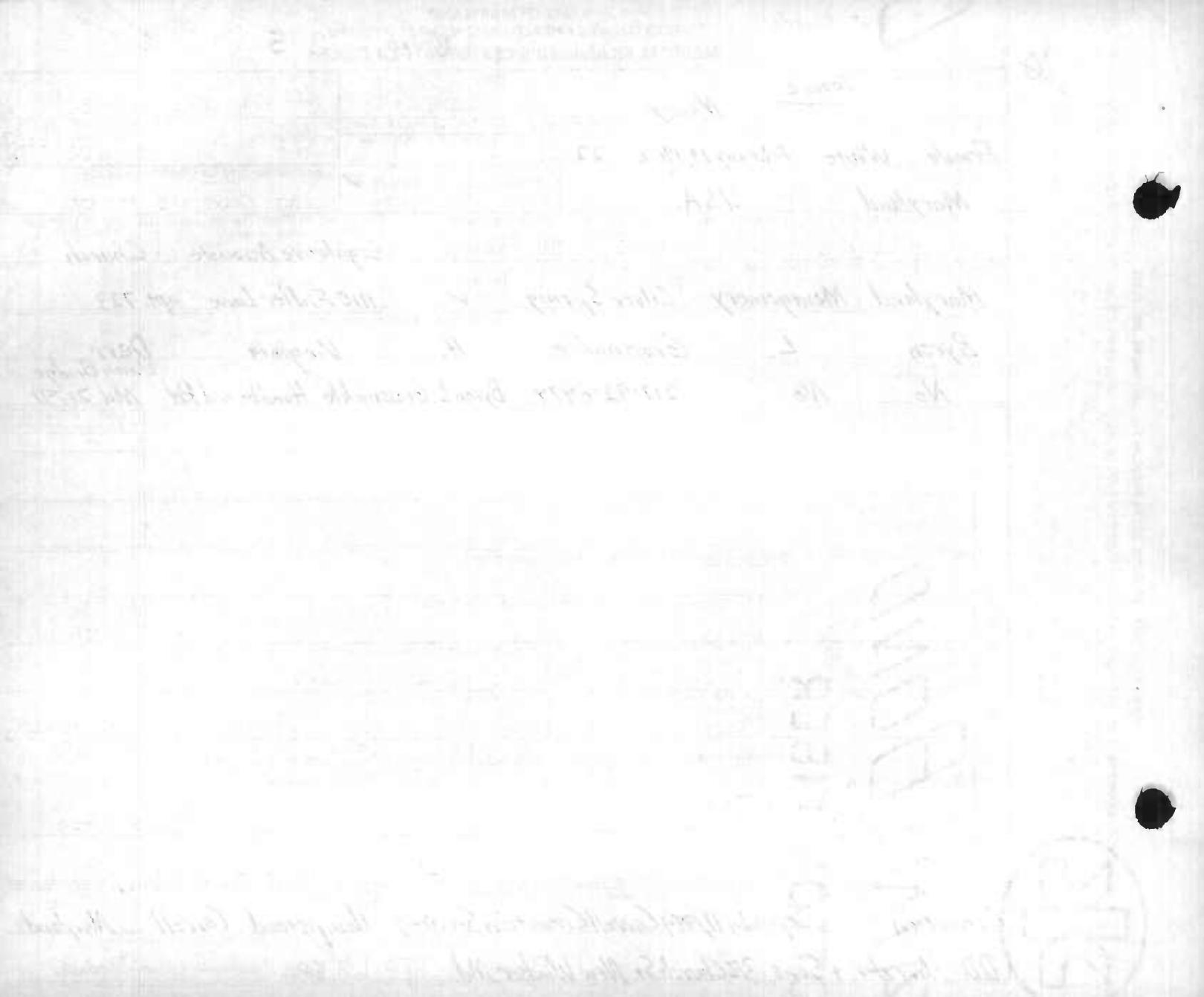
IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25511							
										REG. NO.							
1 - FOR STATE REGISTRAR			MAUDE			GROSS			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR			
									9-5-84					10:45AM			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female			Black			MONTH 4 DAY 17 YEAR 07			77			YEARS		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland			U.S.A.									PRINCE GEORGE's COUNTY					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			(DO NOT INCLUDE FACILITY CODE STREET ADDRESS)			12a. USUAL OCCUPATION			(TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
CLINTON			SOUTHERN MARYLAND HOSPITAL CENTER						Housewife						None		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
13a. STATE MD			13b. COUNTY P.G.			13c. CITY OR TOWN Upper Marl.			13d. INSIDE CITY LIMITS?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8504 Westphalia Rd		20772		
14. FATHER'S NAME			FIRST Henry			LAST Boone			15. MOTHER'S MAIDEN NAME			FIRST Mary			LAST Dorsey		
Thomas												Jane					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			16c. PART I. DEATH WAS CAUSED BY			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO			218-24-7095			IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT			Noble Gross			8504 Westphalia Road			6 WEEKS		
Upper Marlboro, MD 20772																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I. DEATH WAS CAUSED BY																	
IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
PULMONARY INFILTRATES																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
			HOUR A.M. MONTH DAY YEAR			P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (the hospital) attended the deceased from 7/29, 19 84, to 9/5 19 84, that (I) (the doctor) saw the deceased alive on 9/4 19 84, and that in (my) (his) opinion death occurred on the date and hour and from the causes stated above, (I) (the doctor) (did not) view the body after death.																	
22b. SIGNATURE						DEGREE			MO			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			6188 OXON HILL RD. OXON HILL, MD.						9/5/84		
P. WISOTSKY, M.D.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION			CITY OR TOWN			COUNTY	STATE	
Burial			9/11/84			Resurrection Cemetery									Clinton	Prince George's Co., MD	
24. FUNERAL DIRECTOR NAME			ROLLINS FUNERAL HOME, INC.			ADDRESS			25. DATE			SEPTEMBER 1984			SIGNATURE		
						4339 HUNT PLACE, N.E.											
WASHINGTON, D.C. 20019																	

**ROLLINS FUNERAL HOME, INC.**  
4336 HUNT PLACE, N.E.  
WENatchee, Washington 99361

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 3, WHICH SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										5 5 1 2 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST <u>Joanne</u> JO ANN			MIDDLE <u>Nancy</u>			LAST <u>GROSSNICKLE</u>			2a. DATE KNOWN OF ESTI. DEATH MATED		MONTH MAY	DAY 19 84	YEAR	2b HOUR M
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YR. MONTHS DAYS		8 IF UNDER 24 HRS. HOURS MIN		9c. DATE PRONOUNCED DEAD		MONTH 9	DAY 9	YEAR 19 84	2d HOUR 6:37 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		7c. MARRIED WIDOWED		7d. NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Cottage City			wooded area - 3454 Bladensburg Rd.										<u>Legislative Associate</u>			<u>Church</u>	
13. STATE <u>Maryland</u>			13b. COUNTY <u>Montgomery</u>			13c. CITY OR TOWN <u>Silver Spring</u>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>1110 Fiddler Lane apt. 723</u>						
14. FATHER'S NAME FIRST <u>Byron</u>			MIDDLE <u>L</u>			LAST <u>Grossnickle</u>			15. MOTHER'S MAIDEN NAME FIRST <u>H</u>		MIDDLE <u>Virginia</u>			LAST <u>Derr</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>No</u>			16b. SOCIAL SECURITY NO. <u>217-92-6474</u>			17. INFORMANT			ADDRESS <u>Byron L. Grossnickle Handboard Rd Md 21791</u>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple stab wounds</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. <u>9-3/4-</u> 19 84			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject was stabbed.											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>found in woods</u>			21f. LOCATION STREET <u>3454 Bladensburg Rd.</u> , CITY OR TOWN <u>Cottage City</u> , COUNTY <u>Prince George's</u> STATE <u>Md.</u>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>Ann M. Dixon</u>																TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) <u>Ann M. Dixon, M.D.</u>																DATE SIGNED <u>9-10-84</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <u>September 11, 1984</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>Carroll Cremation Services</u>			23d. LOCATION CITY OR TOWN <u>Hampstead</u>		COUNTY <u>Carroll</u>		STATE <u>Maryland</u>				
24. FUNERAL DIRECTOR NAME <u>D.D. Hartzer + Sons</u>			ADDRESS <u>310 Church St. New Windsor Md.</u>			25a. DATE REC'D. BY REGISTRAR <u>SEP 13 1984</u>			25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>								
DHMH - 17 (VR A15 ME (5)) 20M 4/B2																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						25513		
						REG. NO.		
1. FOR STATE REGISTRAR	FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2d. HOUR
1. DECEASED NAME (TYPE OR PRINT)	LOUISE	N	GUMMEL	09	01	84		12:07pm
3. SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR July 30 1888	6. AGE (IN YEARS LAST BIRTHDAY) 96	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY					
10 CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION SOUTHERN MARYLAND HOSPITAL CENTER				12a USUAL OCCUPATION Homusewife	12b. KIND OF BUSINESS OR INDUSTRY Home		
13a STATE Maryland	13b COUNTY Pr Geo	13c CITY OR TOWN Suitland	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 4705 Medora Drive 20746				
14. FATHER'S NAME FIRST Frederick	MIDDLE	LAST Festner	15. MOTHER'S MAIDEN NAME					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)	16b SOCIAL SECURITY NO. 220 20 2369	17. INFORMANT June Newlan	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio-pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Heart Block</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Recent right cerebral hemisphere infarction</u>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Hypertension, Atherosclerotic heart disease</u>						20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET	CITY OR TOWN	COUNTY	STATE			
22a I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>9/11 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	22b. SIGNATURE <u>M. Chandra, M.D.</u>				DEGREE	22c. DATE SIGNED <u>9/11/84</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. CHANDRA, M.D.	22e. ADDRESS 9131 PISCATAWAY ROAD, CLINTON MD 20735				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 2 Sept 1984	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory	23d. LOCATION CITY OR TOWN Suitland	23e. COUNTY Maryland				
24. FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home Suitland Maryland	25a. DATE REC'D. BY REGISTRAR SEP 06 1984				25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Pendle</u>			

8 Dec 19

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial and permit. Then please remove carbon paper. Pages 1 and 2 should be filled within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

## MEDICAL CERTIFICATION

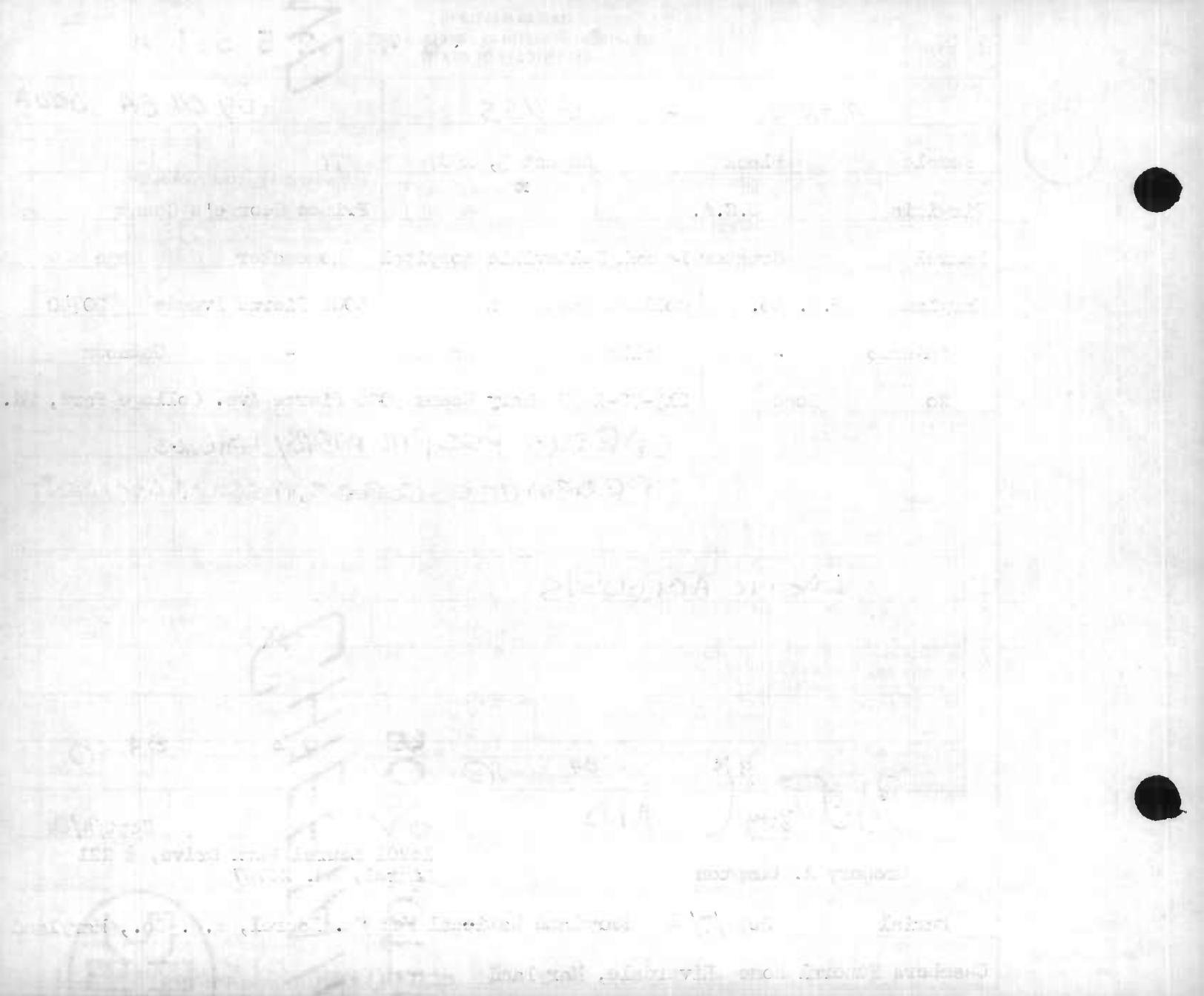
1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

25514

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>MARIE</b>	MIDDLE -	LAST <b>GUSS</b>	2a. DATE OF DEATH MONTH DAY YEAR <b>August 3, 1984</b>	MONTH DAY YEAR <b>9 04 84</b>	2b. HOUR IF UNDER 12 HRS. MONTHS DAYS HOURS MIN. <b>1000 A.M.</b>
3. SEX <b>Female</b>		4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>August 3, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77 YRS.</b>		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD</b>		
CITY OR TOWN OF DEATH <b>Laurel</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Laurel Beltsville Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>P.G. Co.</b>	13c. CITY OR TOWN <b>College Park</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5006 Pierce Avenue 20740</b>		
14. FATHER'S NAME FIRST <b>Anderson</b>		MIDDLE -	LAST <b>Walls</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Nannie</b>		MIDDLE -	LAST <b>Unknown</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None 215-72-1759</b>		17. INFORMANT <b>Mary Weems 5006 Pierce Ave. College Park, Md.</b>		ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PROBABLE CEREBROVASCULAR ACCIDENT</b> DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>LACTIC ACIDOSIS</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>9/4/84</b> , to <b>9/4/84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did not view the body after death.								
22b. SIGNATURE <b>Gregory A. Compton</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>Sept 4/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gregory A. Compton</b>		22e. ADDRESS <b>14201 Laurel Park Drive, # 221 Laurel, Md. 20707</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept 7/84</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Maryland National Mem Pk. Laurel, P.G. Co., Maryland</b>		23d. LOCATION CITY OR TOWN	COUNTY	STATE	
24. FUNERAL DIRECTOR NAME <b>Chambers Funeral Home Riverdale, Maryland</b>		ADDRESS <b>Chambers Funeral Home Riverdale, Maryland</b>	25a. DATE REC'D. BY REGISTRAR <b>SEP 10/84</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Kauder Pendell</b>			

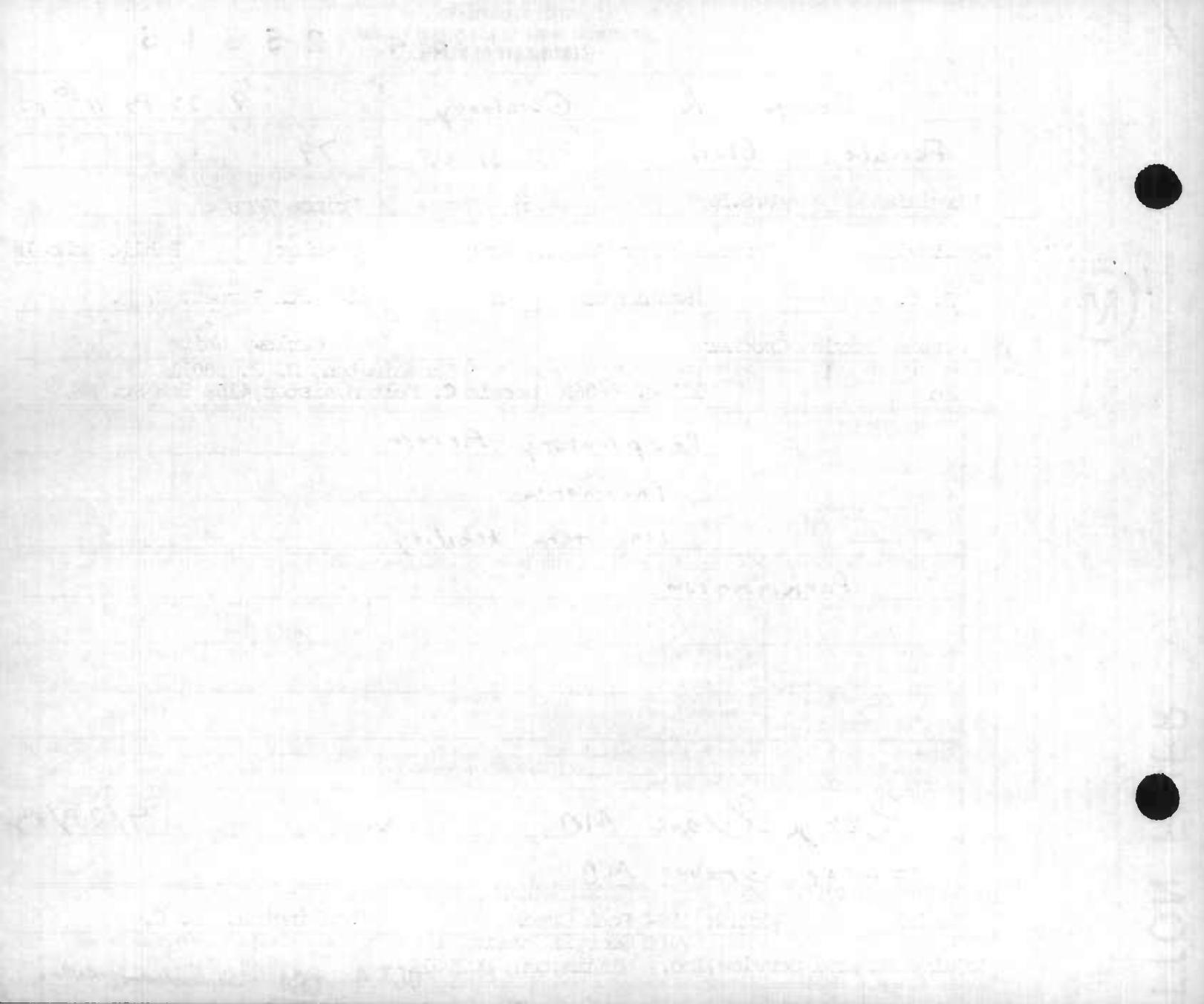


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the funeral director, page 3 should be detached for use as the burial/stan permit. Then please remove carbon paper. Pages 1 and 2 may be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

9999999  
BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25515	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Jessie R Gwaltney						9 27 84						11:30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Black		MONTH	DAY	YEAR	79			MONTHS	DAYS	HOURS	MIN.
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Prince George MD.			
Virginia		U.S.A.		Carroll Manor Nursing Home			10a. CITY OR TOWN OF DEATH			10b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Hyattsville							Hyattsville			Teacher Public Schools			
13a. USUAL RESIDENCE IF IN HOSPITAL, HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION												13b. STREET ADDRESS / ZIP CODE	
D. C.		COUNTY		13c. CITY OR TOWN			Washington			4108 5th Street, N. W.		94499	
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
Jessie Charles Crocker						Curlew White							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS				
No			225-42-4606A			Washington, D. C. 20011			Bessie C. Felton, sister, 4108 5th St. NW,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Pneumonia													
DUE TO, OR AS A CONSEQUENCE OF: (c) long term debility													
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Parkinsonism													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (II) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED	
22b. SIGNATURE George Graves M.D.			DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			9/28/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Graves M.D.			22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 2, 1984			23c. NAME OF CEMETERY OR CREMATORIAL Rock Creek			23d. LOCATION CITY OR TOWN Washington, D. C. COUNTY STATE				
24. FUNERAL DIRECTOR NAME McGuire Funeral Service, Inc., Washington, DC20012			ADDRESS 7400 Georgia Avenue, NW			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
						OCT 4 1984						Lisa Davidson Pendleton	
DHMH - 1650M 4/83 (VRA 15, 4)													



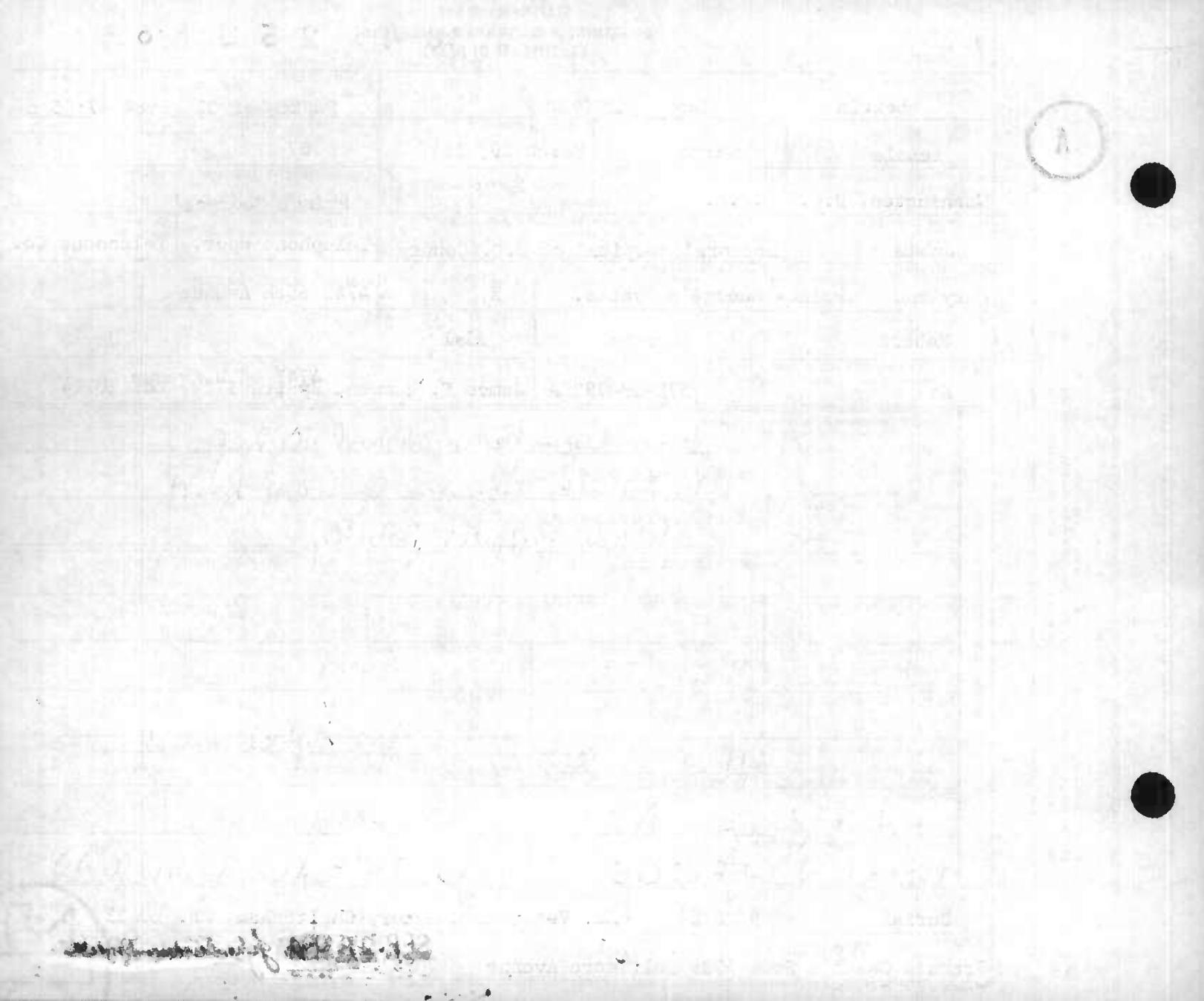
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

### MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 25516			
1 - FOR STATE REGISTRAR	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)	Lorrie	May	HAMMOND	September 22	1984			7:45 am	
3. SEX	female	4. RACE	white	5. DATE OF BIRTH	MONTH March	DAY 26	YEAR 1917	6. AGE (IN YEARS LAST BIRTHDAY) 67 IF UNDER 1 YEAR YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges'			
10. CITY OR TOWN OF DEATH	Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of P.G. County			12a. USUAL OCCUPATION Telephone Oper.			12b. KIND OF BUSINESS OR INDUSTRY Telephone Co.	
13a. STATE Maryland	13b. COUNTY Prince George's	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 4743 68th Avenue 20784			
14. FATHER'S NAME Robert	MIDDLE	LAST Amman	15. MOTHER'S MAIDEN NAME Alma			16. ADDRESS 4743 68th Avenue Hyattsville, Md. 20784			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 578-09-7929A	17. INFORMANT James F. Hammond			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Severe Upper Gastrointestinal Bleeding</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic Terminal Cancer of Breast</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>alcohol Gasitis perforata</i>				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 22</u> , 19 <u>82</u> , to <u>Sept 22</u> , 19 <u>84</u> , that (II) (we) lost saw the deceased alive on <u>Sept 22</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (II) (we) (did) (did not) view the body after death.						22c. DATE SIGNED			
22b. SIGNATURE <i>Robert J. Gerig</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ROBERT J. GERIG</i>	22e. ADDRESS 4416 74th Ave Hyattsville MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/26/84	23c. NAME OF CEMETERY OR CREMATORIAL Md. Veterans Cemetery	23d. LOCATION CITY OR TOWN Cheltenham, Md.	23e. COUNTY 20623	STATE				
24. FUNERAL DIRECTOR NAME Francis Gasch's Sons	ADDRESS 4739 Baltimore Avenue	25. DATE SEP 22 1984							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached from the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25517	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
TRACYE MICHELLE HART						09	05	84	8 40A M		
3. SEX			4. RACE		S. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE			AFRO AMER 2		6 MONTH 5 DAY 1960	24		MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
WASHINGTON, DC			U.S.A.			PRINCE GEORGES					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
CHEVERLY			PRINCE GEORGES GENERAL HOSPITAL		UNEMPLOYED						
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE		303 68th PLACE 20743		
MARYLAND			P.G.	SEAT PLEASANT							
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	MIDDLE	LAST	ANDERSON		
JOE					HART	GEORGIA	WHITE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT	ADDRESS		2425 SKYLAND PL S.E. JOANNE WILLIAMS AUNT-WASHINGTON, D.C. 20020			
NO			214-82-2683								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BLEEDING DISEASE WITH HEMOPERITONEUM AND DUE TO, OR AS A CONSEQUENCE OF BLEEDING IN SKIN AND WALL OF INTESTINES											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <b>SYSTEMIC LUPUS ERYTHEMATOSUS, ANEMIA</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (1) (this hospital) attended the deceased from 814 to 815, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did/did not view the body after death.											
22b. SIGNATURE											
22c. DATE SIGNED											
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22g. DATE REC'D. BY REGISTRAR		
WILLIE C. BLAIR M.D.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
BURIAL			9/8/84		HARMONY MEMORIAL PARK		LANDOVER		SEP 17 1984	John Blair, M.D.	
24. FUNERAL DIRECTOR NAME			ADDRESS								
ROBERT G. MASON 1661 GOOD HOPE RD. S.E. WASH, D.C.											

100-11432

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 25518				
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR 9 11 84									2b HOUR P.M.				
1. DECEASED NAME (TYPE OR PRINT) George B. Harvey			MIDDLE			LAST			6. AGE (IN YEARS LAST BIRTHDAY) MONTHS 77 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
3. SEX Male			4 RACE White			5. DATE OF BIRTH MONTH October 28, 1906			YEAR							
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.							
10 CITY OR TOWN OF DEATH Riverdale			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital			12a USUAL OCCUPATION Automotive Painter D.C. Gov't.			12b KIND OF BUSINESS OR INDUSTRY							
13a STATE Maryland			13b COUNTY P.G.			13c CITY OR TOWN Glenn Dale			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE Box 158 Glenn Dale Road 20706				
14. FATHER'S NAME FIRST William			MIDDLE			LAST Harvey			15. MOTHER'S MAIDEN NAME FIRST Minnie			MIDDLE			LAST Bolleson	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes-Army			16b SOCIAL SECURITY NO. W.W.II			17 INFORMANT Mrs. Doris E. Omahony Lanham Seabrook, Md.			ADDRESS 9335 Dubarry Ave.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 day	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metabolic Acidosis			DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Renal Failure			DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Heart Failure									6 weeks 6 weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
Atherosclerosis, Coronary Arteritis																
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)										
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN			COUNTY			STATE	
22a I certify that (I) (this hospital) attended the deceased from 27 July 1984 to 11 Sept 1984, that (I) (we) last saw the deceased alive on 11 Sept 1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b SIGNATURE Thomas M. Hutchins, M.D.						22c DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d DATE SIGNED 9/11/84				
22e PHYSICIAN'S NAME (TYPE OR PRINT) Thomas M. Hutchins, M.D.						22e ADDRESS 6214 Landover Rd. Landover, Maryland										
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE Sept. 14, 1984			23c NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery			23d LOCATION CITY OR TOWN Brentwood			COUNTY P.G.			STATE Maryland	
24 FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland						25a DATE REC'D. BY REGISTRAR SEP 17 1984						25b REGISTRAR'S SIGNATURE Julie Gardner				
DHMH - 16 50M 4/83 (VRA 15, 4)																



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					25519							
					REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR					
ANNIE C. HAWKINS			SEPT. 09-1984				8.30 P.M.					
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
Female		Black	Nov. 21, 1898		86		YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Virginia		U.S.A.			PRINCE GEORGE'S COUNTY		MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
CHEVERLY		PRINCE GEORGE GENERAL HOSPITAL			Domestic							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS / ZIP CODE							
13a. STATE		13b. COUNTY	13c. CITY OR TOWN		PGYES <input type="checkbox"/> NO <input type="checkbox"/>		703 62nd Ave			20743		
Maryland		Fairmont	Heights									
14. FATHER'S NAME FIRST		MIDDLE	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST					
unknown			Cornelia Price									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT			ADDRESS						
no		578 26 0435	807 59th Avenue			Anna Marshall-Granddaughter-						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: . IMMEDIATE CAUSE (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Congestive Cardiomyopathy</i> (c) <i>Coronary arrest</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED  WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (i) this hospital attended the deceased from <i>9/16/84</i> , to <i>9/17/84</i> , that (ii) we last saw the deceased alive on <i>9/16/84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (if any) (did) (did not) view the body after death.												
22b. SIGNATURE <i>J. Vaughn M.D.</i>										DEGREE <i>m.d.</i>	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	21g. DATE SIGNED <i>9/10/84</i>
22e. PHYSICIAN'S NAME (TYPE OR PRINT)										22f. ADDRESS <i>6492 Landover Rd. Landover, MD. 20785</i>		
23a. BURIAL, CREMATION, REMOVAL		23b. DATE <i>Sept. 14, 1984</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Maryland National</i>		23d. LOCATION CITY OR TOWN		Laurel, Maryland					
24. FUNERAL DIRECTOR NAME <i>John T. Stewart III</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 17 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John T. Stewart III</i>								
Stewart Funeral Home-4001 Benning Road, NE												



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 8 shows any injury, or other traumatic event, the medical examiner will be notified of same.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 25520				
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 9/20/84							2b. HOUR 4:35A M				
1. DECEASED NAME FIRST MIDDLE LAST SHIRLEY T HENSON														
3. SEX Female			4. RACE Black		5 DATE OF BIRTH MONTH DAY YEAR Jan 10, 1934			6. AGE (IN YEARS LAST BIRTHDAY) 50			IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Washington, D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE COUNTY, MD.						
10 CITY OR TOWN OF DEATH CLINTON			11. NAME OF HOSPITAL NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher			12b. KIND OF BUSINESS OR INDUSTRY 20870	
13a. STATE Maryland		13b. COUNTY PG		13c. CITY OR TOWN Largo			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 250 Harry S. Truman Drive				
14. FATHER'S NAME FIRST MIDDLE LAST Ignatius Jones			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Maynard											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 577 52 5914			17. INFORMANT Lawrence B. Henson-son			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung with metastases										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET Feb. 84 CITY OR TOWN Sept. 20, 1984 COUNTY STATE								
22a. I certify that (I) this hospital attended the deceased from Sept. 20, 1984, to 19, 19, that (I) (we) last saw the deceased alive on above, (I) (we) did not see the body after death.														
22b. SIGNATURE Victor S. Chupkovich, M.D.			22c. DEGREE							22d. DATE SIGNED 9/20/84				
22e. ADDRESS 9131 Piscataway Rd., Clinton, Md. 20735														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 21, 1984			23c. NAME OF CEMETERY OR CREMATORIAL Harmony Memorial Park			23d. LOCATION CITY OR TOWN Landover, Md. COUNTY STATE					
24. FUNERAL DIRECTOR NAME John Stewart			24a. DATE REC'D. BY REGISTRAR 1984							25b. REGISTRAR'S SIGNATURE June Davidson-Kendall				
Stewart Funeral Home - 4001 Benning Road, NE, 8														

6500.00

All expenses

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 25521				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
Abraham					Hill, Sr.	9 2			84	3:00	A M					
3. SEX		Male	4. RACE		Black	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
						MONTH	DAY	YEAR	78			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		Md	7b. CITIZEN OF WHAT COUNTRY?		U.s.a.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
10. CITY OR TOWN OF DEATH		Riverdale	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		Leland Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			Unemployed None				
13a. STATE		Md	13b. COUNTY		P.G.	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			Hyattsville Md. 7206 West Park Road 20783	
14. FATHER'S NAME		Andrew Hill	LAST			15. MOTHER'S MAIDEN NAME			LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		No	16b. SOCIAL SECURITY NO.		213 12 1024	17. INFORMANT			ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of Lung</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Heavy Smoking History DUE TO, OR AS A CONSEQUENCE OF (c) <i>Heavy Smoking History</i>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION (GIVEN IN PART 1)(o)																
MEDICAL CERTIFICATION			19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
			21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
			22a. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 9/11					22c. LOCATION STREET CITY OR TOWN COUNTY STATE		9/21 1984				
			23a. I certify that (I) (We) attended the deceased from 9/11 1984 to 9/21 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.													
			23b. SIGNATURE		23c. DEGREE					23d. ADDRESS		23e. DATE SIGNED				
			<i>DR. ABRAHAM DABELA</i>							ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		9/2/84				
			23f. PHYSICIAN'S NAME (TYPE OR PRINT)		23g. ADDRESS					23h. LOCATION CITY OR TOWN COUNTY STATE						
			DR. ABRAHAM DABELA		MMG QUEENSBURY RD RIVERDALE											
23i. BURIAL, CREMATION, REMOVAL (SPECIFY)			23j. DATE		23k. NAME OF CEMETERY OR CREMATORIAL					23l. LOCATION CITY OR TOWN COUNTY STATE						
Burial			9-6-1984		Harmony Cemetery					Landover, Md.						
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR/REGISTRAR'S SIGNATURE													
H. S. Washington & Sons			ADDRESS 4925 Burroughs X							SEP 17 1984						

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verso del 26 marzo 2009 nello studio dell'avv.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours of the death.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 25522													
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 09 20 84									2b. HOUR 4 00A.M.													
1. DECEASED NAME (TYPE OR PRINT) DALE HOFFMAN			MIDDLE			LAST			6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.													
3. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH MONTH 1 DAY 12 YEAR 1935			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA			10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PGG HOSPITAL AND MEDICAL CENTER			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY PRINCE GEORGE'S COUNTY MD.		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 00000													
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 233-56-9882			17. INFORMANT			ADDRESS																
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Mr. John Washington</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</i>																									
DUE TO, OR AS A CONSEQUENCE OF (c) <i>malnutrition</i>																									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>malnutrition</i>																									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <i>21/30</i> CITY OR TOWN <i>9170</i> COUNTY <i>MD</i> STATE <i>9170</i>																			
22a. I certify that (I) this hospital attended the deceased from <i>9/19</i> to <i>9/20</i> , 19 <i>84</i> , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. He (we) (did) (did not) view the body after death.												22c. DATE SIGNED <i>9/28/84</i>													
22b. SIGNATURE <i>Lewis H. Dennis, M.D.</i> DEGREE												ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>													
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEWIS H. DENNIS, M.D.			22e. ADDRESS 831 UNIVERSITY BLVD. E. SILVER SPRING, MD. 20903																						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL			23b. DATE 9-22-84			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN <i>BALTIMORE, MD</i> COUNTY <i>MD</i> STATE <i>MD</i>																
24. FUNERAL DIRECTOR NAME <i>STATE ANATOMY BOARD</i>			ADDRESS <i>BALTIMORE, MD</i>			25a. DATE REC'D. BY REGISTRAR <i>SEP 28 1984</i>			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson Pendell</i>																



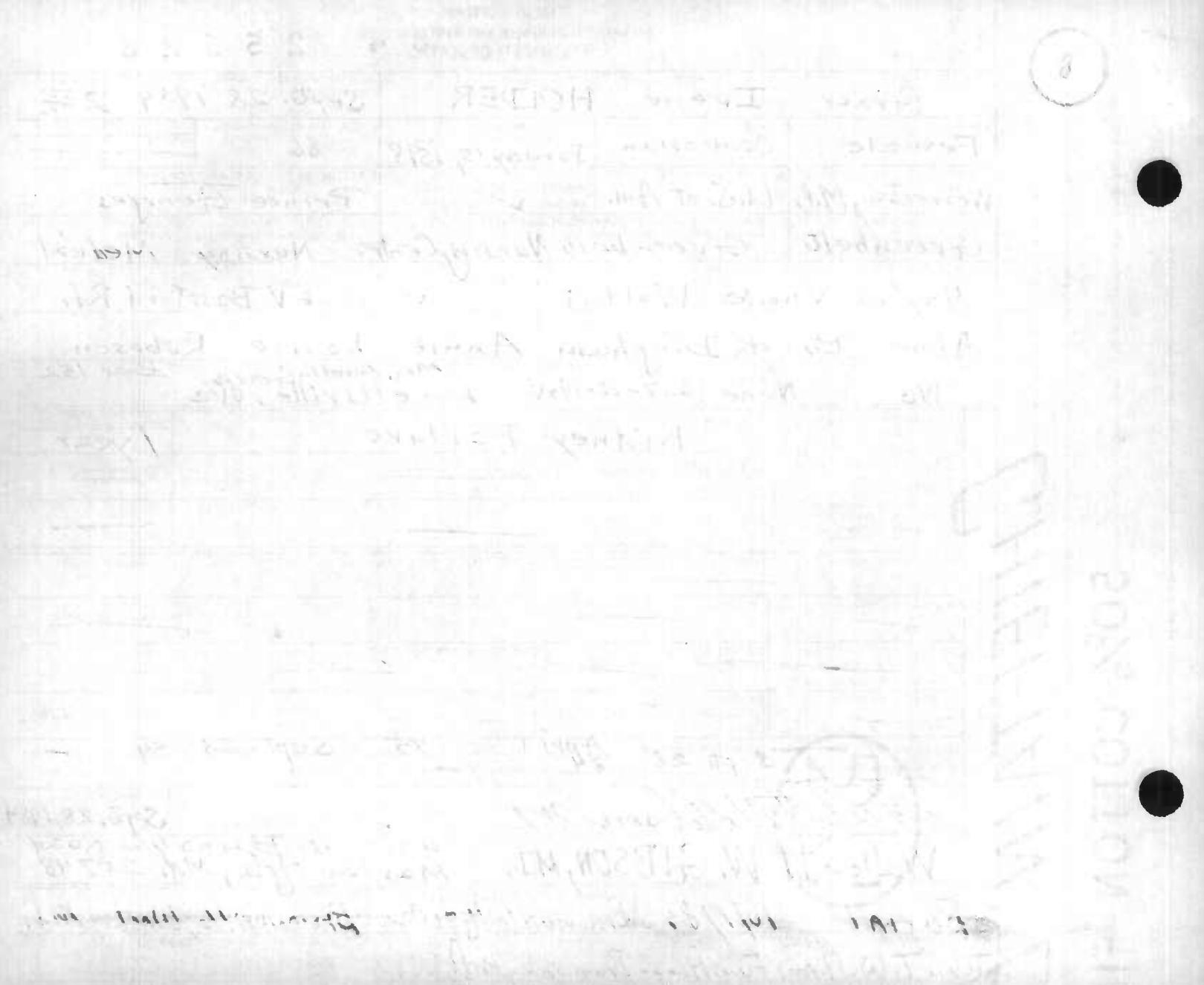
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, postpaid carbon copies, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25523
												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
Grace Irene HOLDER						Sept. 28 1984						250 P.M.
3. SEX Female			4. RACE Caucasian		5. DATE OF BIRTH January 15, 1898			6. AGE (IN YEARS LAST BIRTHDAY) 86			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE Weverton, Md.			7b. CITIZEN OF WHAT COUNTRY? U.S. of Am.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.				
10. CITY OR TOWN OF DEATH Greenbelty			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A SUCH FACILITY, GIVE STREET ADDRESS) Greenbelt Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nursing			12b. KIND OF BUSINESS OR INDUSTRY Medical				
13a. STATE Maryland			13b. COUNTY Charles		13c. CITY OR TOWN Waldorf			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 1206 V Bassford Rd.	
14. FATHER'S NAME Abner Brock Bingham					15. MOTHER'S MAIDEN NAME Annie Laurie Robeson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Andie George			ADDRESS Box 152 Lorettsville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Kidney Failure								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)									
			(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART II)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <input type="checkbox"/> attended the deceased from April 1, 1984, to Sept. 28, 1984, that (I) <input type="checkbox"/> last saw the deceased alive on Sept. 28, 1984, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did <input type="checkbox"/> not view the body after death.												
22b. SIGNATURE Walcutt W. Gibson MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Sept. 28, 1984			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Walcutt W. GIBSON, MD,			22e. ADDRESS 4300 St. Barnabas Road Marlboro, Md. 20748									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/1/84			23c. NAME OF CEMETERY OR CREMATORIAL Brownsville Hills Cemetery			23d. LOCATION CITY OR TOWN Brownsville, Wash., Md.			
24. FUNERAL DIRECTOR NAME John T. Williams Fun. Home - Brunswick, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR OCT 3 1984			25b. REGISTRAR'S SIGNATURE Julie Davidson-Randall			

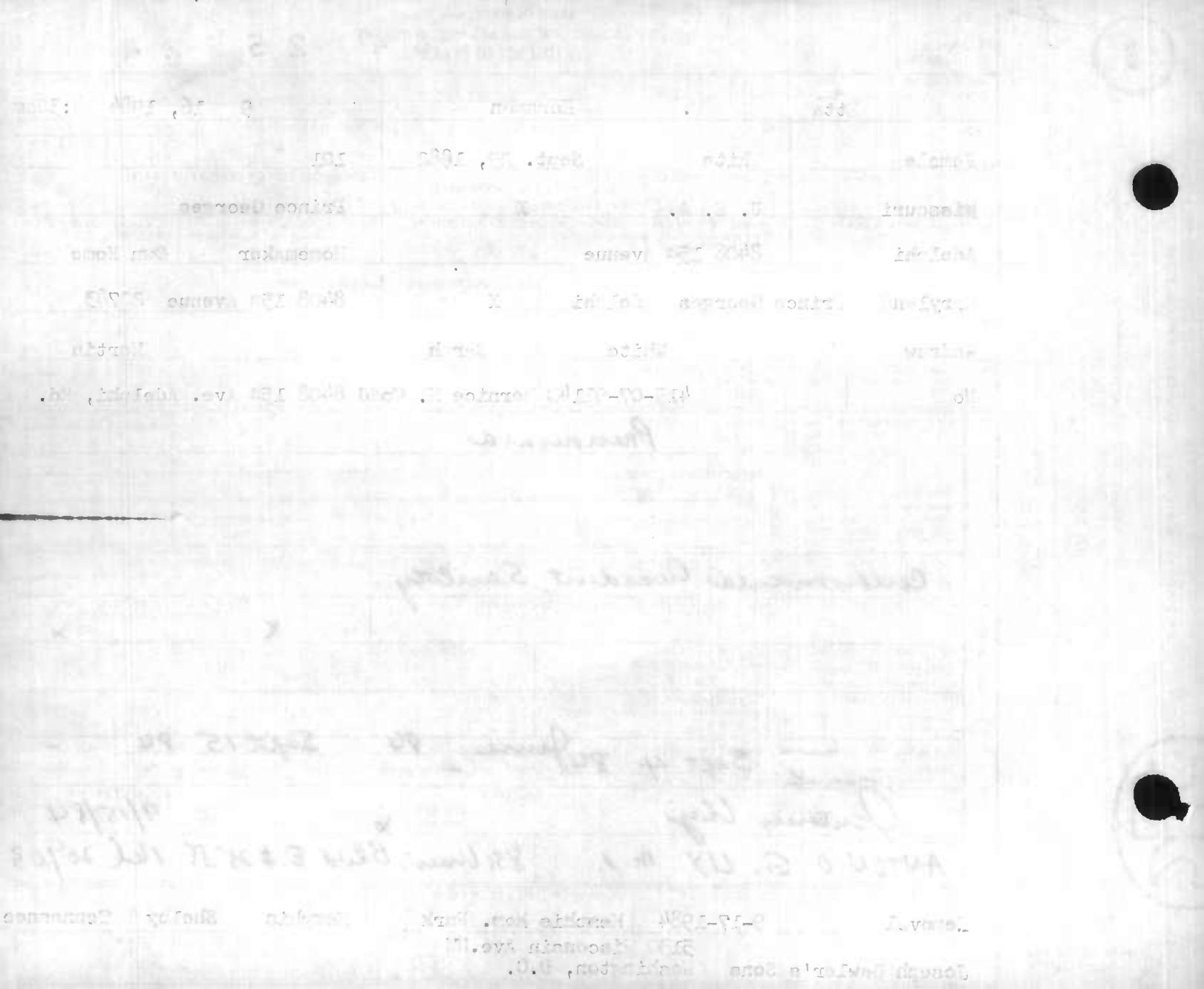


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 25524				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
Etta W. Horsman						9	16	1984				4:30am				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
Female		White		Sept. 29, 1982			101 YRS									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY						
Missouri		U. S. A.					Prince Georges MD.			Homemaker Own Home						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
Adelphi		8408 15th Avenue		Maryland Prince Georges Adelphi			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			8408 15th Avenue 20783						
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
Andrew		White		Sarah			No			413-07-9114D			Bernice H. Todd 8408 15th Ave. Adelphi, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) _____																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____																
DUE TO, OR AS A CONSEQUENCE OF (c) _____																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>Cerebrovascular accident, Senility.</i>																
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE				
22a. I certify that (I) <i>the hospital</i> attended the deceased from <i>Sept 4 84</i> , to <i>Sept 15 84</i> , that (I) <i>we</i> lost saw the deceased alive on <i>Sept 4 84</i> , and that in (my) <i>no</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>very</i> <i>did</i> <i>not</i> view the body after death.																
22b. SIGNATURE <i>Antonio Uy</i>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>9/15/84</i>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANTONIO G. UY M.D.		22e. ADDRESS <i>831 Univ. Blvd E. #2555. Tel 20903</i>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 9-17-1984		23c. NAME OF CEMETERY OR CREMATORIAL Memphis Mem. Park			23d. LOCATION CITY OR TOWN Memphis			COUNTY		STATE				
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons		5130 Wisconsin Ave. NW Washington, D.C.		25a. DATE REC'D. BY REGISTRAR SEP 19 1984			25b. REGISTRAR'S SIGNATURE <i>J. Davidson-Randall</i>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25525	REG. NO.								
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR							
			Robert E. Hughes						6 SEP 84			0810 AM							
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR							
Male			Caucasian			Dec. 19 1929			54			MONTHS DAYS		IF UNDER 24 HRS					
YRS.																			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
Kentucky			U.S.A.						Prince George's										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Camp Springs			Malcolm Grow USAF Medical Center			Criminal Reviewer			Fed. Gov't.			20745							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE							
Maryland			Prince George			Oxon Hill						6909 Elkins Avenue							
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME			LAST										
FIRST William			Hughes			FIRST Sarah			Fritts										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Yes			1948-1970			Marilyn Hughes			6909 Elkins Avenue Oxon Hill, Maryland			10 minutes							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>																			
DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC MALIGNANT MELANOMA</u>																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Metastatic Malignant Melanoma</u>																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c) <u></u>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>14 Aug 84</u> , 19 <u>84</u> , to <u>6 Sept</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>6 Sept</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																			
22b. SIGNATURE <u>William S. Sykora</u>										DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>6 Sept 84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM S. SYKORA										22e. ADDRESS MALCOLM GROW USAF MEDICAL CENTER AAFB, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 9/11/84			23c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l. Cemetery Arlington			23d. LOCATION CITY OR TOWN			COUNTY		STATE					
												Virginia							
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home										6160 Oxon Hill Rd. AUDIT			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE						
													SEP 10 1984						

1990-91

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												2 5 5 2 6	
1- STATE REGISTRAR		FIRST			MIDDLE			LAST			2a DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR		
(TYPE OR PRINT)		MARY			Elizabeth			JENKINS			OF ESTI- DEATH MATED <input type="checkbox"/> 9 07 1984 M		
3. SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		2b. HOUR	
Female		White		Month Day Year		Last Birthday		Months Days		Hours Min.		2d HOUR 10:20 p.m.	
Aug 20 08		75 yrs.											
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		Prince George's		MD.	
Maryland		United States											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
District Heights		2307 Rochelle Avenue		Cafeteria Asst.		PG Bd of Education							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Maryland		PG		District Hts		YES <input type="checkbox"/>		2307 Rochelle Ave		20747			
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		Marra			
		Antonio		Ruffo				Rosaria					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		--		212-01-7472		Mary Wilene Jenkins		Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain tumor</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(b) _____ DUE TO, OR AS A CONSEQUENCE OF													
(c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?									
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED 9/8/1984							
EXAMINER'S NAME (TYPE OR PRINT)		Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct., Temple Hills, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 11Sept84		23c. NAME OF CEMETERY OR CREMATORIAL St. Michael's Cem		23d. LOCATION CITY OR TOWN Frostburg		COUNTY		STATE Md.			
Burial													
24. FUNERAL DIRECTOR Robert E. Wilhelm		ADDRESS Suitland, Md.		25a. DATE REC'D BY REGISTRAR SEP 13 1984		25b. REGISTRAR'S SIGNATURE <i>Jane Davidson-Rodriguez</i>							
Funeral Home													

A

SEARCHED INDEXED SERIALIZED FILED



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON IN STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG'D. NO. 27
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR
Leroy			Leonard	Jodrie	<input checked="" type="checkbox"/>	Sept 12 1984	PM					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR
Male	White	Jan. 21, 1924	60 RS.			<input checked="" type="checkbox"/>	Sept 13 1984	PM				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH			
Massachusetts			U.S.A.			<input checked="" type="checkbox"/>			Prince George's County			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT A HOSPITAL, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
College Park			9291 Rhode Island Ave.			Retired Printer			U.S. Gov't.			
13a. STATE Maryland			13b. COUNTY P.G.			13c. CITY OR TOWN College Park			14. FATHER'S NAME FIRST			
									LAST			
Alton			D.			Jodrie			Marion			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. W.W.II			17. INFORMANT Mrs. Rita V. Jodrie			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial Dwi</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			ADDRESS Address Same as No# 13e.
												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John S. Rogers</i>			TITLE (SPECIFY) M.D. <i>D.P.</i>			MEDICAL EXAMINER			DATE SIGNED <i>Sept 13 1984</i>			
EXAMINER'S NAME (TYPE OR PRINT)			1919 Seminary Rd. Silver Springs, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Removal 9/14/84			23c. NAME OF CEMETERY OR CREMATORIAL Balto., Md.			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME			Anatomy Board			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
F. Gasch's Sons F.H. P.A. Hyattsville, Maryland						SEP 18 1984			<i>Lia Wilson-Rendell</i>			
20M 4/B2												

### Classification

1707-1710

- 5 -

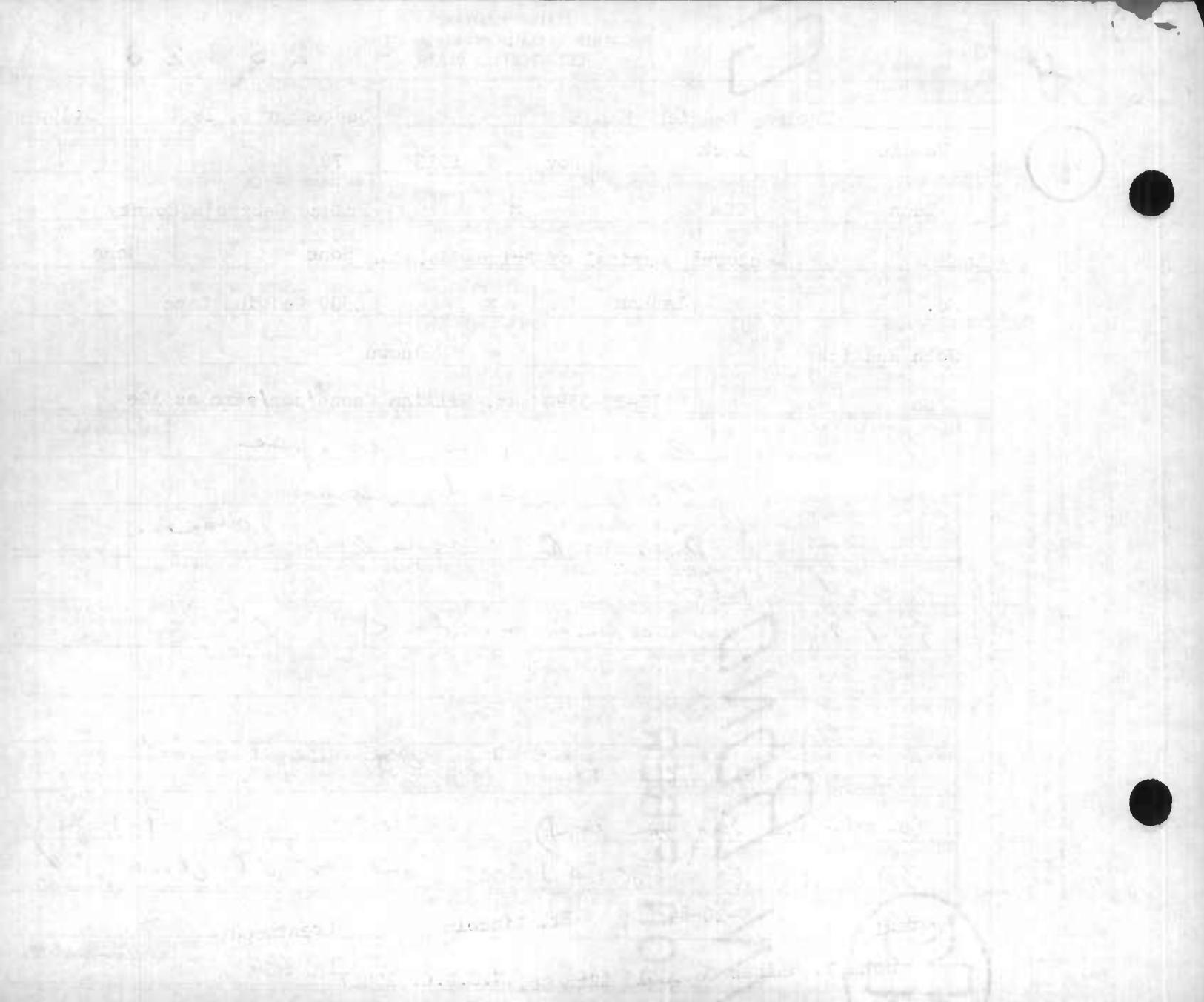
*L. 1900. V. 11. P. 1. 1900. 1900.*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for us as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 25528					
1 - FOR STATE REGISTRAR			1a. DECEASED NAME (TYPE OR PRINT)				1b. DATE OF DEATH			2b. HOUR					
			First Middle Last <b>Thelma Reddick KEENE</b>				Month Day Year <b>September 6, 1984</b>			5:10 p m					
3. SEX <b>Female</b>			4. RACE <b>Black</b>		5. DATE OF BIRTH Month Day Year <b>Nov 9 1913</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b>			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tenn</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD.</b>							
10. CITY OR TOWN OF DEATH <b>Lanham</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Doctors' Hospital of PrinceGeo'sCo.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>					
13a. STATE <b>Md.</b>			13b. COUNTY		13c. CITY OR TOWN <b>Lanham</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>8509 Redwing Lane 20706</b>				
14. FATHER'S NAME First Middle Last <b>John Reddick</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Unknown</b>												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>072-20-3390</b>				17. INFORMANT <b>Mr. William Keene/son/same as 13e</b>			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cards vascular collapse</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Blood loss and sepsis</i>															
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Primary Bacteremia arterial disease.</i>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>renal failure</i>															
19a. DATE OF OPERATION <b>9-4-84</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>aortic anas smic leak</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 23</b> , 19 <b>84</b> to <b>Sept 6</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>Aug 31</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>John T. Rhines Co., 3015 12th St., N.E.D.C.</i>										DEGREE					
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John T. Rhines Co., 3015 12th St., N.E.D.C.</i>										ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	DATE SIGNED <b>9-7-84</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>9-10-84</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln</b>			23d. LOCATION CITY OR TOWN <b>Brentwood</b>			COUNTY <b>Md.</b>		STATE		
24. FUNERAL DIRECTOR NAME <b>John T. Rhines Co., 3015 12th St., N.E.D.C.</b>										25a. DATE REC'D. BY REGISTRAR <b>SEP 13 1984</b>				25b. REGISTRAR'S SIGNATURE <i>John T. Rhines Co., 3015 12th St., N.E.D.C.</i>	
ADDRESS <b>20017</b>															



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 8. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED IN WITH FORM PM. 3 FOR YOUR FILES. RETAIN PAGES 3 AND 4 FOR YOUR RECORDS. 72 HOUR PERMIT WILL NOT BE ISSUED.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2 5 5 2 9						
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTIMATED	XX	MONTH	DAY	YEAR	2b. HOUR	
		GEORGE						KEMP				9	27	1984	M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		2d. HOUR
Male		White		3 28 24		60						9		27		8:23		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		Prince George		p. m.				
Penns.		USA																
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY								
Andrews AFB		Malcolm Grow USAF Medical Ctr.				Retired				Carpenter								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS										
Maryland		Pr. George		Ft. Washington		3744 Lumar Dr. 20744												
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME										
		George				Kemp		First Gwen		Last Johns								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.				17. INFORMANT		ADDRESS										
yes		WWII				189-18-8626		Ann A. Kemp same as item 13										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic obstructive pulmonary disease.</i> DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF																		
(c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?												
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE								
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>												TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER						
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.												DATE SIGNED 9/28/1984						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM				23d. LOCATION CITY OR TOWN		COUNTY		STATE						
Burial		10/1/84		Md. Veteran Cemetery				Cheltenham		P.G.		Md.						
24. FUNERAL DIRECTOR NAME		ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE										
G.P. Kalas		6160 Oxon Hill Rd. Oxon Hill, Md.				OCT 1 1984		<i>Julia Davidson-Pendall</i>										
DHMH - 17 (VR A15 ME (5))																		
20M 4/82																		

private garage

X

Att

same

prefer

beauti

good location good location

the switch

convenient

not afraid

crossing

sidewalk

It will be area quiet

**Medical Examiner Notified - Released to PMD**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

**MEDICAL CERTIFICATION**

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 25530						
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	September 14, 1984							7:45 PM			
Helen Jeannette KING																
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
Female			White		May 30 1912			72 YRS.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				Prince Georges County				
Washington, D.C.			U. S. A.													
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY		
Lanham			Doctor's Hospital of P.G. County							Secretary				U.S. Gov't.		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE				
Maryland			Dr. Geo.		Hyattsville							20784 7718 Garrison Road				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	ADDRESS				
William King						Margaret			J.		Donaldson	4902 Monroe St.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.							17. INFORMANT			Gilbert S. Whitfield Bladensburg, Maryland			
No			578-09-0773													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cardio pulmonary arrest.</i>													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute myocardial infarction</i>																
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes - Coronary artery disease - Hypertension</i>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Gout - Congestive heart failure</i>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)										
			P.M. 19													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1982</i> , 19 <i>84</i> , to <i>9/14</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>Sept 14</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													22c. DATE SIGNED <i>9/15/84</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert Gereige M.D.</i>													22e. DEGREE			
													ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN				COUNTY		STATE	
Burial			9-18-1984			Glenwood Cemetery			Washington				D. C.			
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Francis Gasch's Sons, P.A. Hyattsville, Md.													<i>Julia Davidson-Kendall</i>			
						SEP 19 1984										

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use of insulation

at 100%

elsewhere

which would cost

about \$17 million which is 10% of the total estimated cost

etc.

heat transfer 85% of all other losses

which is about 10% of the total

IEC says soon

but I think it's probably 10 years

heat transfer 85% of all other losses

providing 100% of the heat

etc.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2 5 5 3 1
1- STATE REGISTRAR		I. DECEASED NAME FIRST MIDDLE LAST						2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH DAY YEAR		2b. HOUR
		RUSSELL THEODORE KITE						<input checked="" type="checkbox"/> <input type="checkbox"/>		9 28 1984		M
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7d. HOUR
Male		White		Dec. 25, 1901		82 yrs.						8:31 a.m.
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		7d. DATE PRONOUNCED DEAD		9. BALTIMORE CITY OR COUNTY OF DEATH		MONTH DAY YEAR		10. BALTIMORE CITY OR COUNTY OF DEATH		MD.
Virginia		U. S. A.		9 28 1984		Prince George's						
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Upper Marlboro		3113 Pyles Drive						Painter (Emplyd)		Retail Stof		Zip
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		13f. ADDRESS		
Maryland		Pr. Geo's		Upper Marlboro		YES <input checked="" type="checkbox"/>		3113 Pyles Drive/ 20772				
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST		LAST		LAST		LAST		
Earl		--		Lena		Koontz		--		Kite		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.						17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
No		577-01-5491						3113 Pyles Drive 20772		Eva May Kite - Upper Marlboro, Md.		
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20d. AUTOPSY?				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) Deputy M.D. MEDICAL EXAMINER						DATE 9/28/1984 SIGNED				
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 5009 Rayburn Ct., Camp Springs, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE		
Burial		10/1/84		Resurrection Cemetery Clinton (Pr. Geo's) Md.		Clinton		Md.				
24. FUNERAL DIRECTOR		Upper Marlboro, Richard A. Coleman Funeral Home Maryland 20772						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
								OCT 1 1984		<i>Julia Davidson-Randall</i>		
BP												
DHMH - 17 (VR A15 ME (5)) 20M 4/B2												

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listed by L.M.C. (continued)

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**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGES 1, 2, AND 3 AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 25532					
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- DEATH MATED						
BONNIE			Ann		KOLANDER			9 10 1984		M							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD					
Female		White		April 18, 1940		44 yrs.						9 10 1984					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County											
Montana		U.S.A.															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Lanham		Doctors' Hospital of P.G. Co.		Housewife		Own Home											
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Lanham		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7502 Wilhelm Drive 20706									
14. FATHER'S NAME George		MIDDLE		LAST Wheeler		15. MOTHER'S MAIDEN NAME Edna		16. ADDRESS Address Same as Mr. Raymond G. Kolander No# 13e.									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 516-48-0165		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		Hypertension cardiovascular disease													
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> Undetermined manner <input type="checkbox"/> death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>Augusto P. Rodriguez, M.D.</i>		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER		DATE SIGNED 9/10/1984											
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct., Temple Hills, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 13, 1984		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood		COUNTY P.G.		STATE Maryland							
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A.		ADDRESS Hyattsville, Maryland		25a. DATE REC'D. BY REGISTRAR Sep 13 1984		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>											
20M 4/82																	
DHMH - 17 (VR A15 ME (5))																	

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APPENDIX A

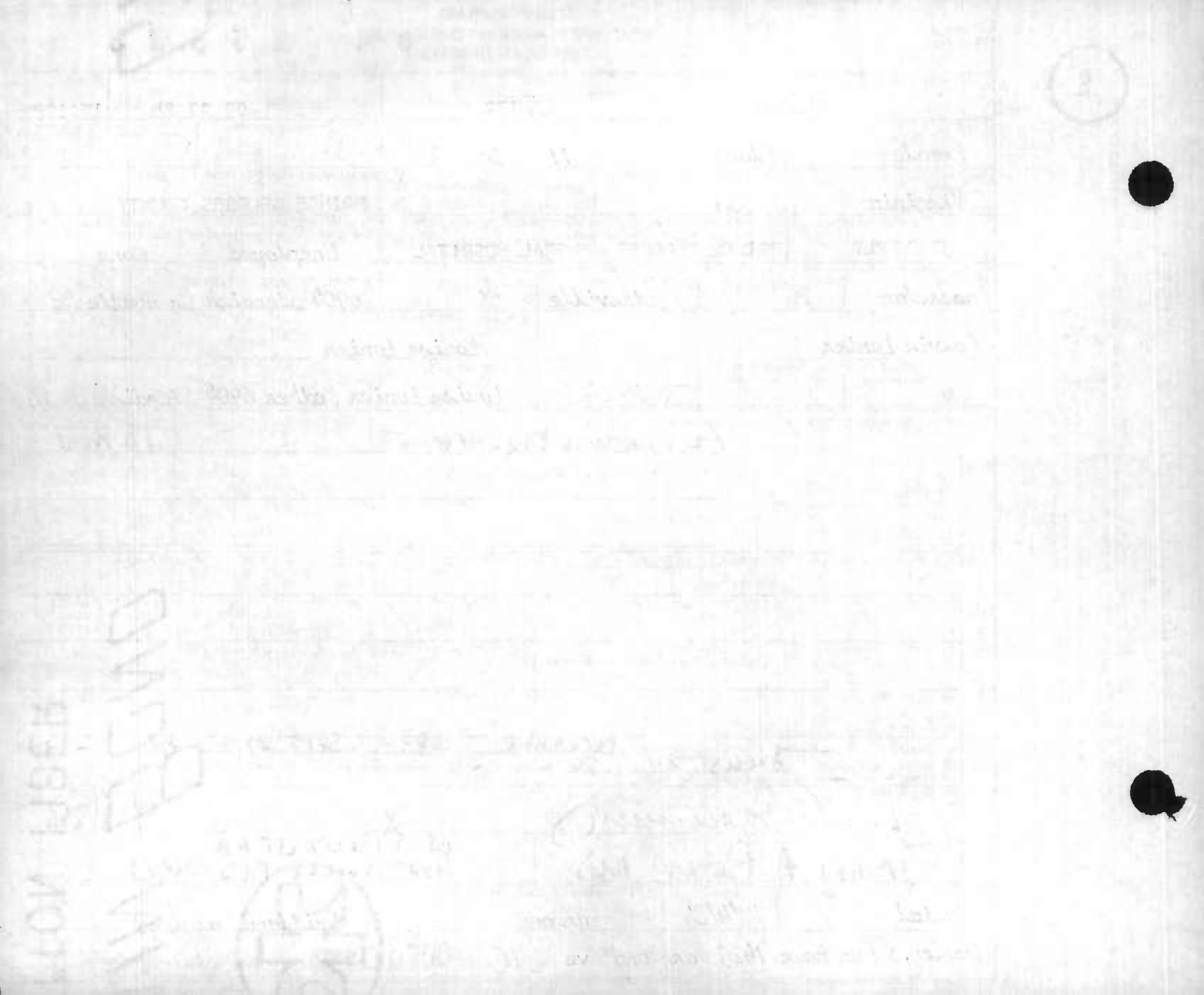
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed within 72 hours after death.

(IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified for view as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.)

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25533							
											REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
GLORIA									LANIER			09 27 84					10:12PM		
1. SEX: <b>Female</b>			4 RACE: <b>Black</b>			5. DATE OF BIRTH			MONTH <b>11</b> DAY <b>28</b> YEAR <b>45</b>			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
7a. BIRTHPLACE (COUNTRY) <b>Virginia</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8.			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES COUNTY MD.</b>		MONTHS		DAYS		HOURS	
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGES GENERAL HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unemployed</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>										
13a. STATE <b>Maryland</b>			13b. COUNTY <b>PG</b>			13c. CITY OR TOWN <b>Hyattsville</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>6904 Standish Dr Hyattsville MD 20784</b>		LAST					
14. FATHER'S NAME <b>Calvin Lanier</b>			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME <b>Louise Lanier</b>			ADDRESS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>578 60 6424</b>			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Glioblastoma Multiforme</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 mos</b>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>										
21d. THE INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE					
22a. I certify that (I) <input type="checkbox"/> (the hospital) attended the deceased from <b>DECEMBER 19 83</b> to <b>SEPT 27 84</b> , that <input type="checkbox"/> (we) last saw the deceased alive on <b>AUGUST 24 1984</b> , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.			22b. SIGNATURE <i>James A. Brown</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>9/28/84</b>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>AMES A. BROWN MD</b>			22e. ADDRESS <b>6125 BELCREST RD HYATTSVILLE MD 20782</b>																
23a. BURIAL, CREMATION, REMOVAL SPECIFY <b>Burial</b>			23b. DATE <b>10/4/84</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Harmony</b>			23d. LOCATION CITY OR TOWN <b>Suitland Maryland</b>			COUNTY		STATE					
24. FUNERAL DIRECTOR <b>Dudley's Fun Home 1425 Maryland Ave NE DC</b>			25a. DATE REC'D. BY REGISTRAR <b>OCT 10 1984</b>			25b. REGISTRAR'S SIGNATURE <b>John Davidson-Pendleton</b>													



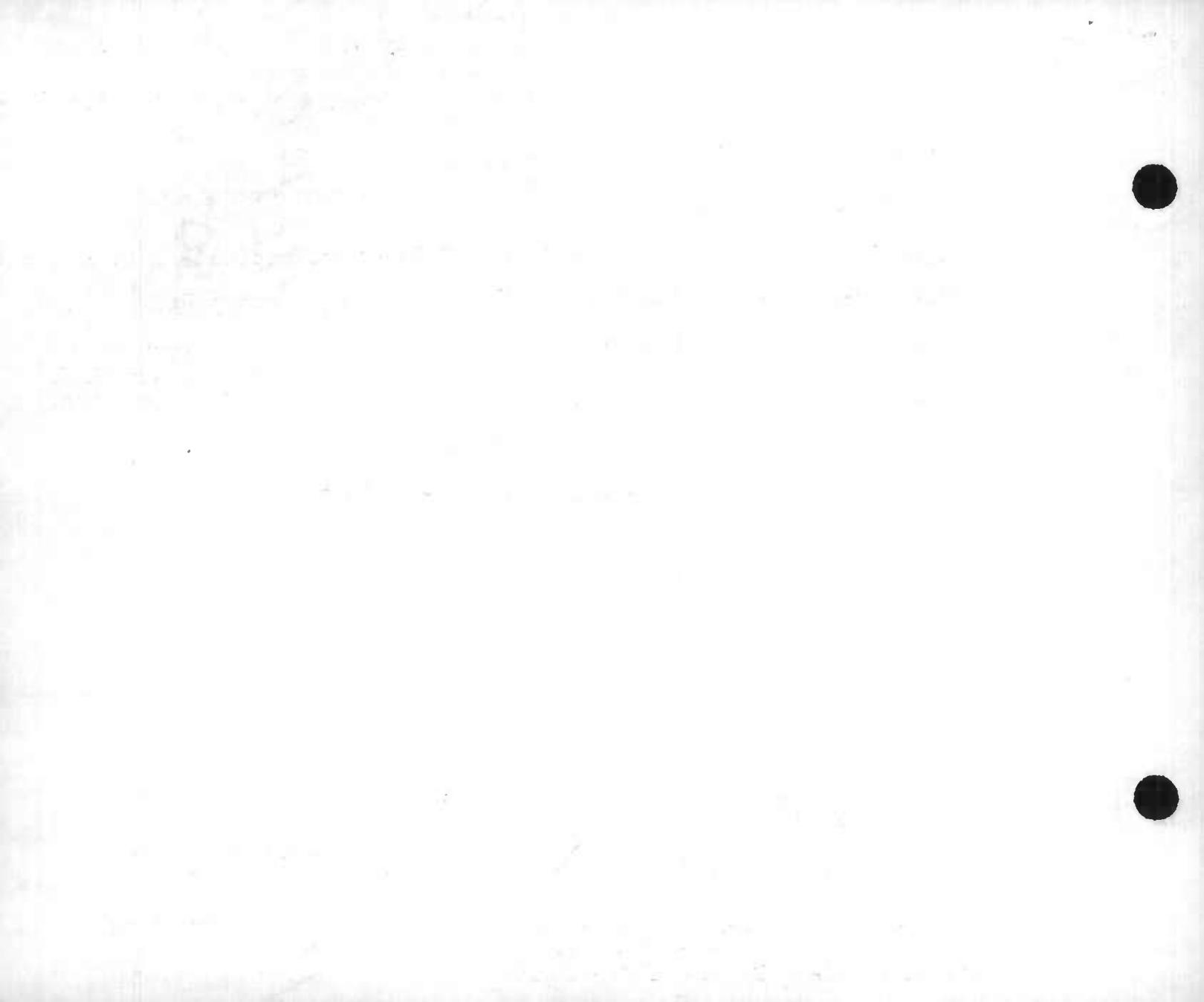
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 25534					
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 29, 1984</b>							2b HOUR <b>7:15 P.M.</b>					
1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>HERMAN</b>	MIDDLE <b>I.</b>	LAST <b>LAZARUS</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>65 YRS.</b>									
3. SEX <b>Male</b>			4 RACE <b>White</b>		S. DATE OF BIRTH MONTH DAY YEAR <b>March 3, 1919</b>	6 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES COUNTY MD.</b>									
10. CITY OR TOWN OF DEATH <b>Laurel</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER LAUREL BELTSVILLE HOSPITAL Merchant (Ret) Int. Decorat</b>							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Merchant (Ret) Int. Decorat</b>					
13a. STATE <b>New York</b>			13b. COUNTY <b>Warren</b>		13c. CITY OR TOWN <b>Glen Falls</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							13e. STREET ADDRESS / ZIP CODE <b>14½ Northup Drive 12801 99999</b>		
14. FATHER'S NAME FIRST <b>Louis</b>			MIDDLE <b></b>	LAST <b>Lazarus</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Tillie</b>							MIDDLE <b></b>	LAST <b>(unknown)</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		16c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b>	17. INFORMANT ADDRESS <b>Glen Falls, New York</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b>			18b. (b) <b>coronary artery disease</b>												
18c. (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF FATHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED			
22b. SIGNATURE <i>R Nath</i>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C.R. NATH, M.D.</b>							22e. DEGREE <b>M.D.</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10-3-1984</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Temple Beth El Cem.</b>							23d. LOCATION CITY OR TOWN <b>Moreau, New York</b>		25a. DATE REC'D. BY REGISTRAR <b>Sept 3 1984</b>	
24. FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>			25b. REGISTRAR'S SIGNATURE <i>Jane Davidson-Pendall</i>												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 84 25535
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Effie M. Leach						9 11 84			10:45 PM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		Cauc.		8 22 14			70					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.					
Wash D.C.		USA										
10. CITY OR TOWN OF DEATH Oxon Hill		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1101 Dumfries St.					12a. USUAL OCCUPATION Retired-Disabled		12b. KIND OF BUSINESS OR INDUSTRY Hairstresser			
Maryland		Pr. George		Oxon Hill			13a. STREET ADDRESS / ZIP CODE 1101 Dumfries St. 20745					
14. FATHER'S NAME Samuel		M. MacMillan		15. MOTHER'S MAIDEN NAME Effie			MIDDLE		LAST		Gray	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 577-05-7769		17. INFORMANT Carter Leach same as item 13			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). CONGESTIVE HEART FAILURE, CHRONIC OBSTRUCTIVE LUNG DISEASE												
19a. DATE OF OPERATION ✓		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5/12 1984 to 9/11 1984, that (I) (we) last saw the deceased alive on 9/11 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Abbas Nachmani</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/12/84						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gurbux H. Nachmani, M.D.		22e. ADDRESS 9015 Woodyard Rd. Clinton, Md. 20735										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9/12/84		23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory		23d. LOCATION CITY OR TOWN		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME G.P. Kalas		ADDRESS 6160 Oxen Hill Rd. Oxen Hill, Md.				25a. DATE REC'D. BY REGISTRAR SEP 14 1984		25b. REGISTRAR'S SIGNATURE <i>Julian Davidson-Rendell</i>				
DHMH - 16 50M 4/83 (VRA 15, 4)												

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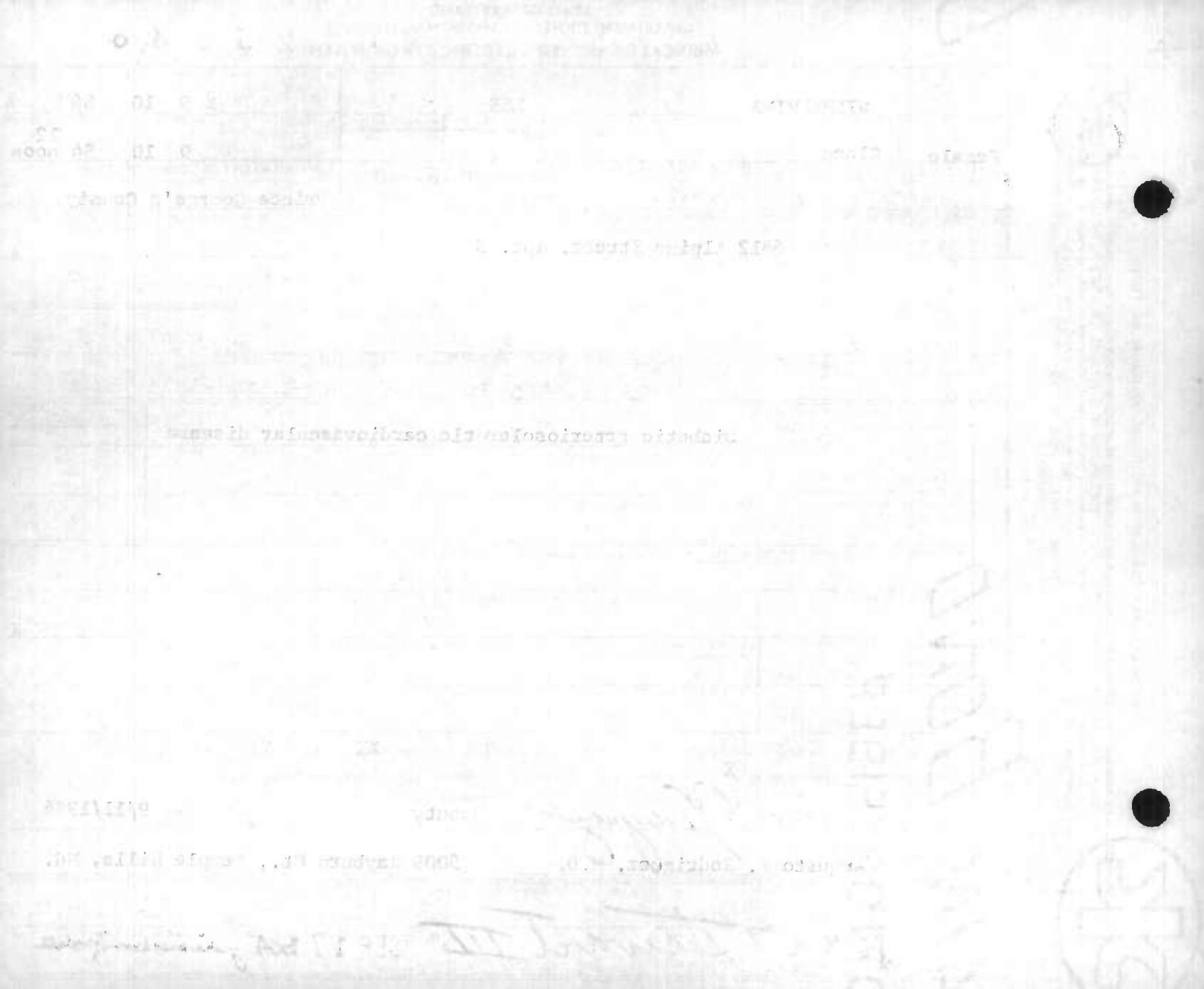
100.00

100.00

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												2 5 5 3 6 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH DAY YEAR			2b. HOUR			
WILHELMINA						LEE						<input checked="" type="checkbox"/> 9 10 1984						M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS (LAST BIRTHDAY)			7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR	
Female		Black		June 25, 1936			Yrs 48			MONTHS		DAYS		HOURS		9. BALTIMORE CITY OR COUNTY OF DEATH			12 noon		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED									Prince George's County			MD.					
South Carolina		U.S.A.																			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Forestville,		6812 Alpine Street, Apt. 3										Cashier			202747						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS											
Maryland		Forestville		PG						6812 Alpine Street											
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST									
Eddie Lee							Effie					(unknown)									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT			17. ADDRESS														
(IE YES, GIVE WAR OR DATES)		no		249 68 0768			Priscilla Lee-niece-1924 Rochell														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetic arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE IN AVE. BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?													20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE								
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>															Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion						
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>															TITLE (SPECIFY) Deputy M.D. MEDICAL EXAMINER			DATE 9/11/1984 SIGNED			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial-Removal Sept 12, 1984			23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery			23d. LOCATION CITY OR TOWN Whiteville, N.C.			COUNTY			STATE							
24. FUNERAL DIRECTOR NAME		John T. Stewart, Jr.			25a. DATE REC'D. BY REGISTRAR SEP 17 1984			25b. REGISTRAR'S SIGNATURE <i>Jane Dawson Rodell</i>													
Stewart Funeral Home-4001 Benning Road, NE.																					
BP _____																					
DHMH - 17 (VR A15 ME (5))																					
20M 4/B2																					

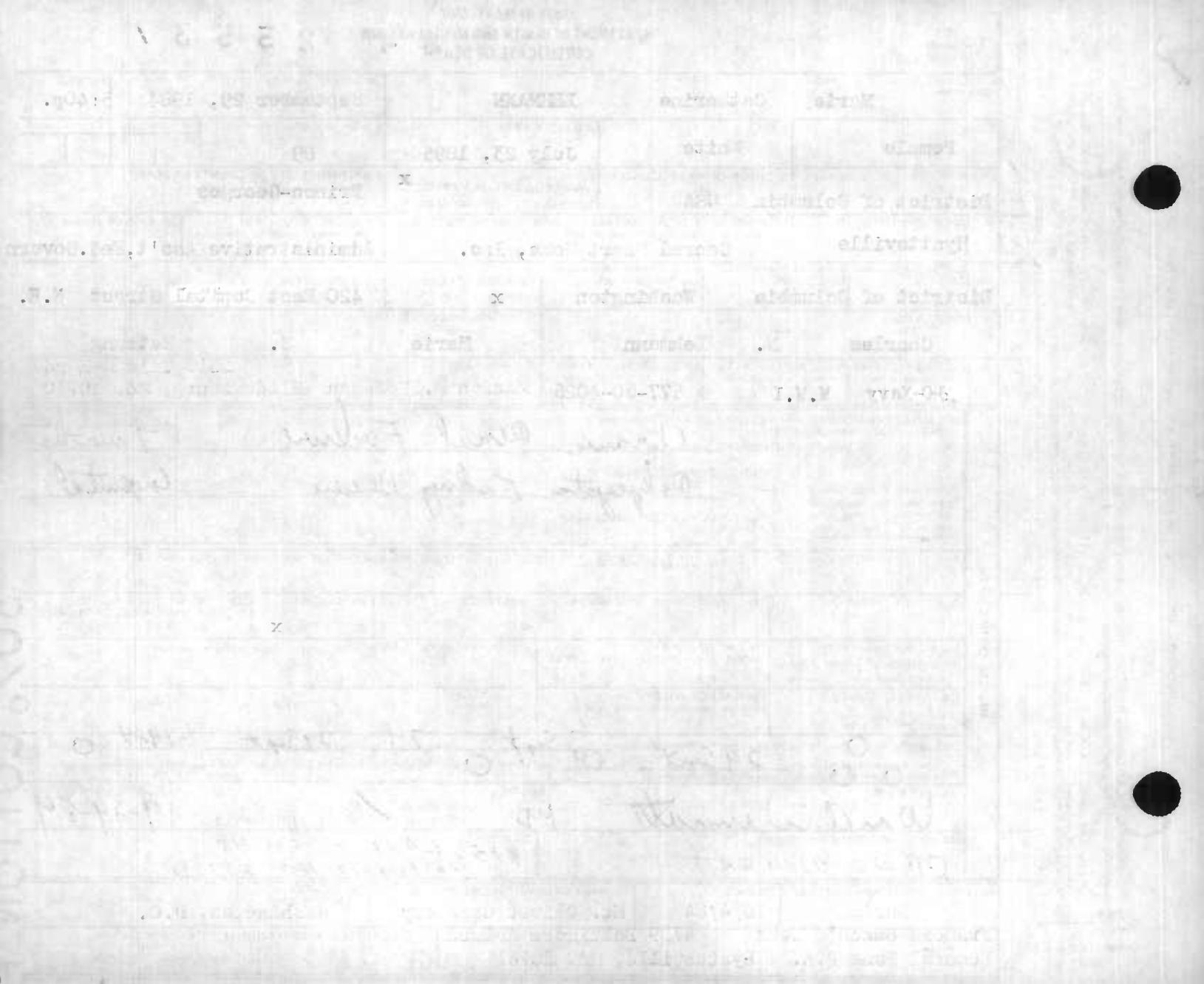


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resubmitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

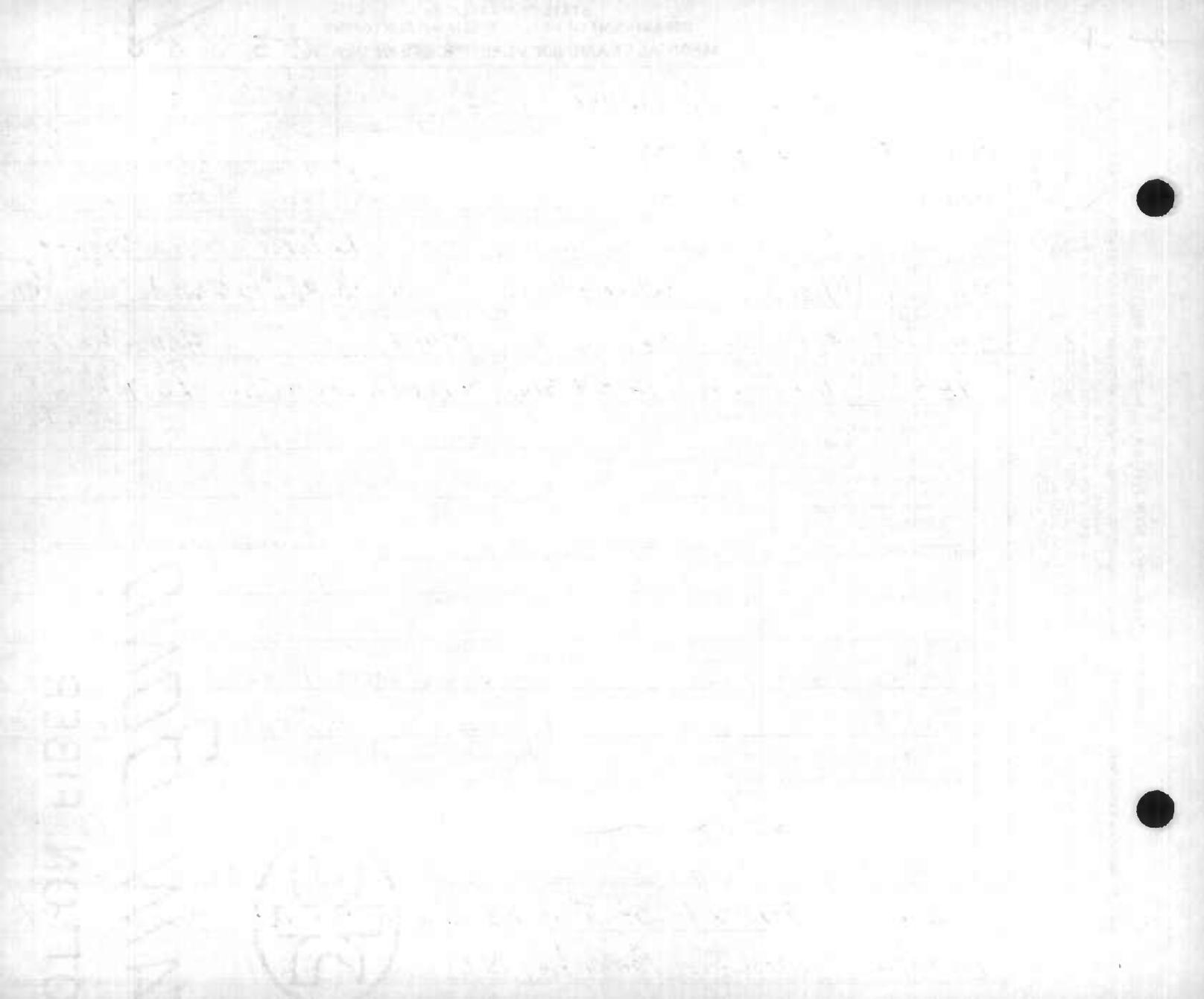
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once!

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 25537			
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR September 29, 1984									2b. HOUR 5:40p. M			
1. DECEASED NAME (TYPE OR PRINT)			FIRST Marie Catherine			MIDDLE			LAST LEHMANN						
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH July DAY 23, YEAR 1895			6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) District of Columbia			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince-Georges						
10. CITY OR TOWN OF DEATH Hyattsville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Home, Inc.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrative Ass't, Fed. Govern			12b. KIND OF BUSINESS OR INDUSTRY 99999			MD.			
13a. STATE District of Columbia			13b. COUNTY District of Columbia			13c. CITY OR TOWN Washington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 420 East Capitol Street N.E.			
14. FATHER'S NAME FIRST Charles MIDDLE N. LAST Lehmann						15. MOTHER'S MAIDEN NAME Marie S. Metzung									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes-Navy			16b. SOCIAL SECURITY NO. W.W.I			17. INFORMANT Marion M. Hoffman			ADDRESS 5313 Tilden Road Bladensburg, Md. 20710						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Renal Failure DUE TO, OR AS A CONSEQUENCE OF (b) Polycystic Kidney Disease DUE TO, OR AS A CONSEQUENCE OF (c) Congenital.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NOT WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) this hospital attended the deceased from <u>saw the deceased alive on</u> <u>29 Sept 89</u> , to <u>29 Sept 19 1984</u> , to <u>19 1984</u> , that (we) lost above (I/we) did (did not) view the body after death.															
22b. SIGNATURE <u>Wm. W. Mimsatt</u>			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9-29-84						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DR WM WIMSATT</u>			22e. ADDRESS 8150 LAKE CREST DR GREENBELT MD - 20770												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/4/84			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery			23d. LOCATION CITY OR TOWN Washington, D.C.			COUNTY	STATE		
24. FUNERAL HOME Francis Giesch's Sons Funeral Home P.A.			4739 Baltimore Avenue ADDRESS Hyattsville, Md. 20781			25a. DATE REC'D. BY REGISTRAR 4CI 5 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Pandelle						

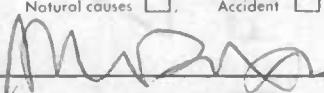


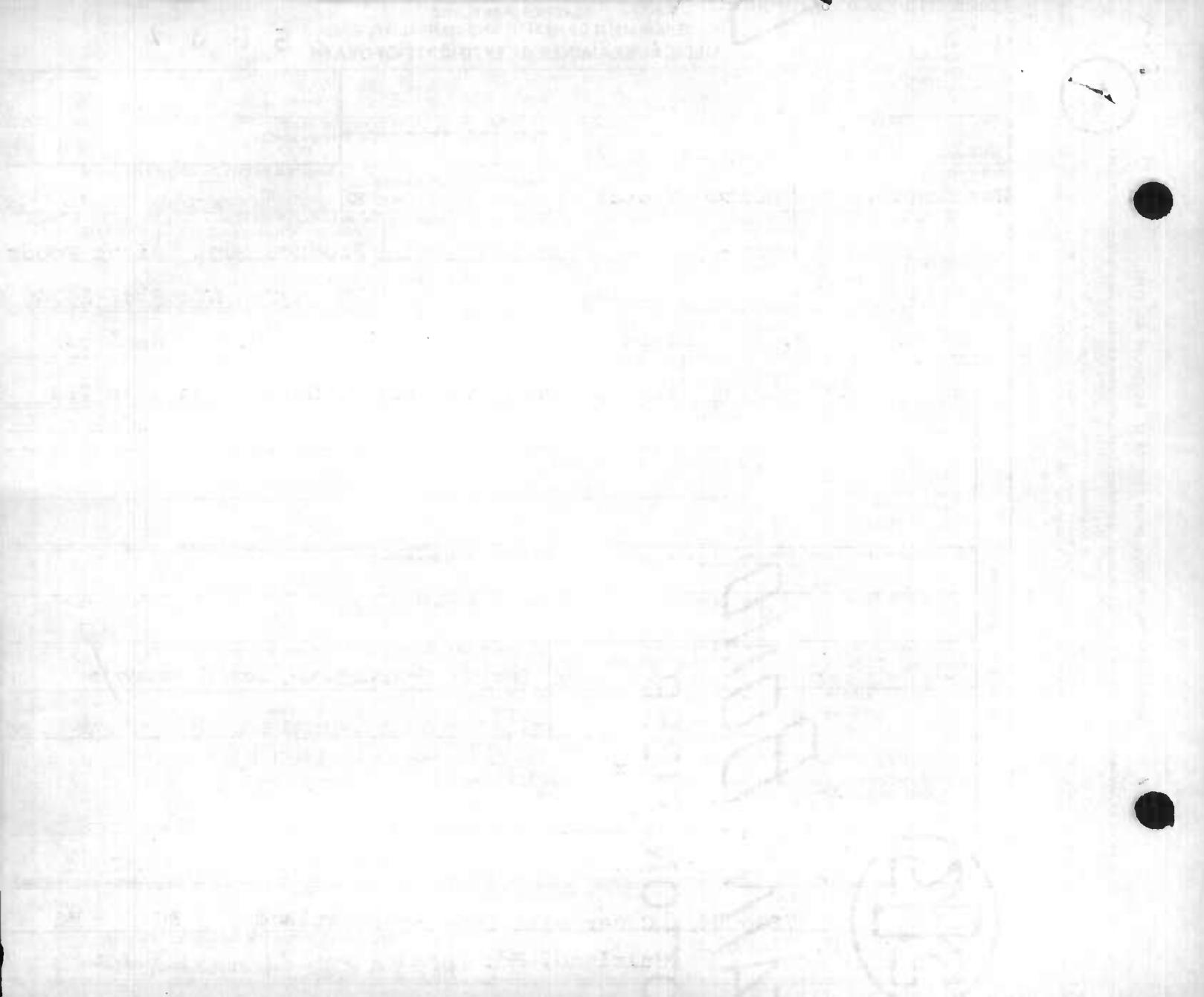
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGES 1, 2, AND 3 FOR YOURSELF. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE FILLED OUT WITHIN 72 HOURS AFTER DEATH. MAIL PAGES 1, 2, AND 3 TO THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2 5 5 3 8	
1- STATE REGISTRAR			2. DATE KNOWN <input checked="" type="checkbox"/> MONTH 9 DAY 9 YEAR 1984										
1. DECEASED NAME (TYPE OR PRINT)			FIRST RICHARD			MIDDLE Alexander			LAST LEWIS			2b. HOUR 10:49 p.m.	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR July 15, 1954		6. AGE (IN YEARS) LAST BIRTHDAY 30 yrs.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 9 1984	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.					
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Gen. Hosp. (DOA)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer			12b. KIND OF BUSINESS OR INDUSTRY Private		
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN White Plains		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS P.O. Box 126 White Plains, Md. 20695					
14. FATHER'S NAME FIRST Samuel		MIDDLE Russell		LAST Lewis Jr.		15. MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE LAST Gooseberry		ADDRESS P.O. Box 1013 La Plata, Md. 20646			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT 212-54-5168		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8136 IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROPRIATE INTERVAL BEFORE AUTOPSY AND DEATH 20646		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <del>xx</del> MONTH DAY YEAR 9:25 M. 9-9- 1984			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Operator of bicycle/auto collision.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road			21f. LOCATION STREET Rt. 301 CITY OR TOWN White Plains, COUNTY Charles, STATE Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 9-10-84	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-13-84			23c. NAME OF CEMETERY OR CREMATORIAL St. Joseph's Church			23d. LOCATION CITY OR TOWN Pomfret COUNTY Charles STATE Md.				
24. FUNERAL DIRECTOR NAME Thornton's Funeral Home			ADDRESS Pomonkey, Md.			25a. DATE REC'D. BY REGISTRAR SEP 11 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Hendell				
DHMH - 17 (VR A15 ME (5)) 20M 4/82													



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR OR MEDICAL EXAMINER ALONG WITH FORM FM 3, RETAIN PAGE 5 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3, RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

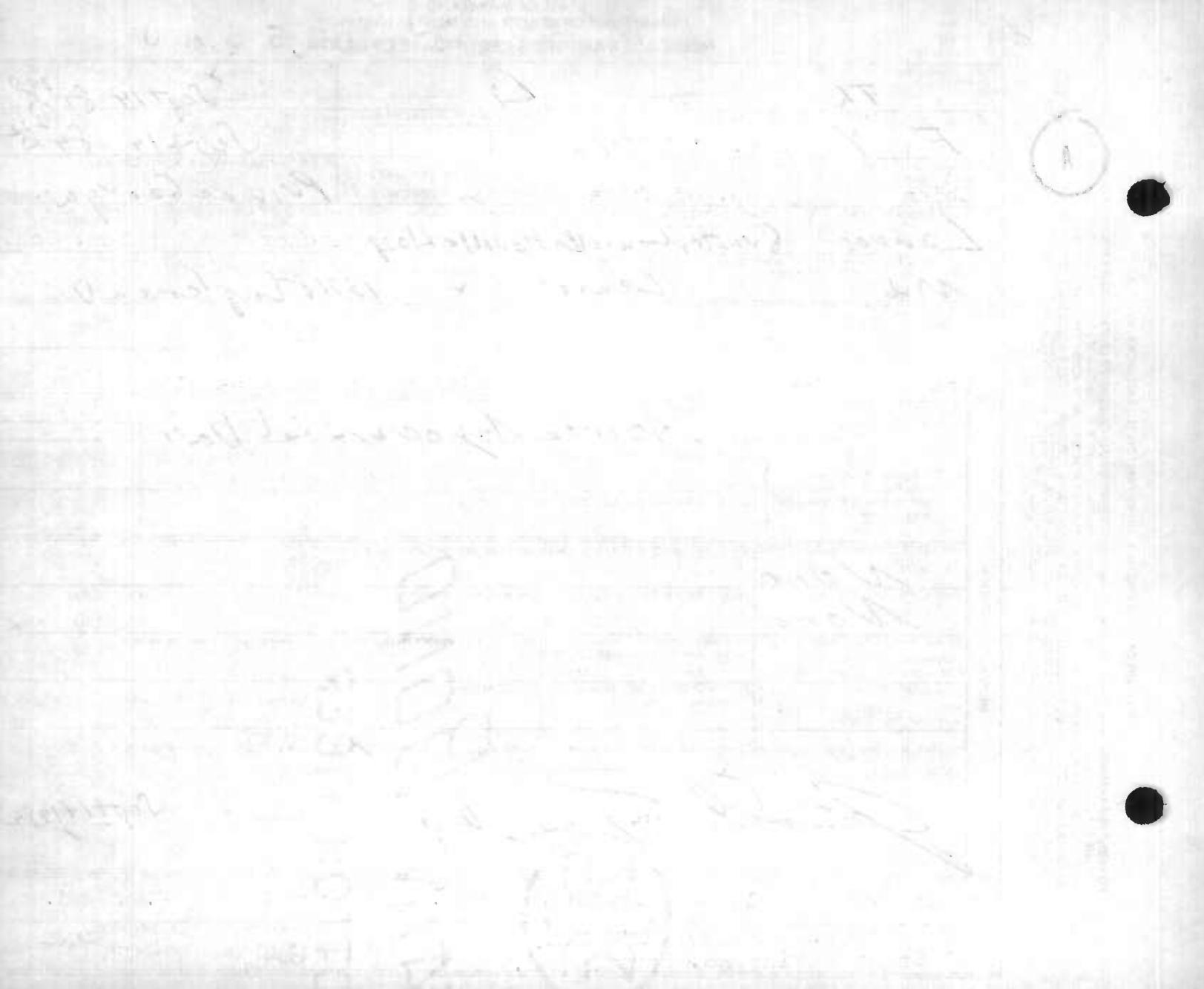
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 5 5 3 9	
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR	
			RUSSELL N. LEWIS						<input checked="" type="checkbox"/> 9-4-5 1984				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD	
Male		White		July 14-48		36 yrs.						9 5 1984 9:25 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Washington, DC		United States								Prince George's County MD.		Produce Dept Giant Foods	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suitland yard - 4738 Huron Ave.										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Maryland		13b. COUNTY PG		13c. CITY OR TOWN Suitland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4785 Huron Ave #13 20746					
14. FATHER'S NAME Elmer		W.		Lewis		15. MOTHER'S MAIDEN NAME Virginia		16. SOCIAL SECURITY NO. 1969-1975		17. INFORMANT Virginia D. Lewis		ADDRESS Same as #13	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		18b. SOCIAL SECURITY NO. 1969-1975		18c. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  9/138 IMMEDIATE CAUSE (a) Hanging DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 9-4-5 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject found hanged. Sexual asphyxia		21d. LOCATION STREET yard		21e. CITY OR TOWN CITY OR TOWN 4738 Huron Ave., Suitland, Prince George's, Md.		COUNTY STATE			
21f. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21g. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
ACTUAL SIGNATURE 												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St., Balto., Md. 21201										DATE SIGNED 9-5-84	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 7 Sept 84		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN Suitland		23e. COUNTY PG		STATE Md.			
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm Funeral Home		25a. DATE REC'D. BY REGISTRAR SEP 14 1984										25b. REGISTRAR'S SIGNATURE Julie Davidson-Randall	
BP _____													
DHMH - 17 (VR A15 ME (5))													
20M 4/82													



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED OUT WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3 5 5 4 0	
1- STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR 230	
			<i>Th Hua Li</i>						<i>Sept 6 1984</i>			M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD	
<i>F</i>		<i>Y</i>		<i>Nov. 21 1912</i>		<i>72 RS.</i>						<i>Oct 14 1984</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
<i>China</i>			<i>Rep. of China</i>						<i>Prince George's, MD.</i>				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
<i>Laurel</i>			<i>Grover Cleveland High School</i>			<i>Teacher</i>			<i>Elem. Sch.</i>				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		20744 <i>13718 Longfellow Dr.</i>			
<i>Md</i>				<i>Laurel</i>									
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			LAST				
			<i>UNKNOWN</i>						<i>UNKNOWN</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
<i>Yes</i>			<i>N/A</i>			<i>William Li</i>			<i>Same as #13e</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial Dasi</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>None</i>													
19a. DATE OF OPERATION <i>None</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> TITLE (SPECIFY) M.D. <i>Drs</i> MEDICAL EXAMINER													
ACTUAL SIGNATURE <i>[Signature]</i>													
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS						DATE SIGNED <i>Sept 14 1984</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL Baltimore Wash. Crem Laurel			23d. LOCATION CITY OR TOWN				
<i>Cremation</i>			<i>9/14/84</i>										
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
<i>FLECK FUNERAL HOME INC.</i>						<i>SEP 17 1984</i>			<i>Julia Davidson-Randall</i>				
7601 Sandy Spring Rd. Laurel, Md.													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial transit permit. Then please remove carbon papers. Papers (Item 2) should be sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 16 shows any injury, or other traumatic event, the medical examiner must be consulted before the death certificate is signed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 2554		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	7a. DATE OF DEATH	MONTH	DAY	YEAR	7b. HOUR		
NELLIE Victoria LIPSCOMB						Sept. 22, 1984				3 P.M.		
3. SEX:		4. RACE:		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female		Black		May 6, 1905			79 YRS					
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?			10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH			
South Carolina USA									Prince Georges			
12. CITY OR TOWN OF DEATH		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A HOSPITAL, GIVE STREET ADDRESS)			14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			16. KIND OF BUSINESS OR INDUSTRY	
Capitol Heights, Maryland		Capitol Heights, 1310 Rollins Avenue			Maryland PG			Retired			U.S. Gover.	
17. FATHER'S NAME FIRST		MIDDLE		LAST	18. MOTHER'S MAIDEN NAME FIRST			19. STREET ADDRESS		20. ADDRESS		
Rufus Mack					Emma			1310 Rollins Avenue		Poole		
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		22. SOCIAL SECURITY NO.			23. INFORMANT			24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO		578 44 2439			Emma Banks-daughter							
18. CAUSE OF DEATH: (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST												
DUE TO, OR AS A CONSEQUENCE OF CARDIOMYOPATHY												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b) _____												
DUE TO, OR AS A CONSEQUENCE OF HYPERTENSIVE CARDIO VASCULAR DISEASE (c) _____												
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) CEREBROVASCULAR ACCIDENTS												
25. MEDICAL CERTIFICATION		26. DATE OF OPERATION		27. CONDITION FOR WHICH OPERATION WAS PERFORMED			28. AUTOPSY?		29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 28, PART I OR PART II)								
33. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		34. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		35. LOCATION STREET			CITY OR TOWN		COUNTY STATE			
36. I certify that (I) (this hospital) attended the deceased from SEPT. 22 1984, to SEPT. 19 1984, that (I) (we) last saw the deceased alive on SEPT. 22 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												
37. SIGNATURE		38. DEGREE		39. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			40. DATE SIGNED					
41. PHYSICIAN'S NAME (TYPE OR PRINT)		42. ADDRESS		43. ADDRESS			44. ADDRESS			45. DATE SIGNED		
HEMANT N JOGLEKAR, M.D.		2041 - GEORGIA AVE. N.W.								SEPT. 24, 1984		
46. BURIAL, CREMATION, REMOVAL (SPECIFY)		47. DATE		48. NAME OF CEMETERY OR CREMATORIUM			49. LOCATION CITY OR TOWN			50. COUNT. STATE		
Burial		Sept. 27 1984		Maryland National Memorial Park			Laurel, Md.					
51. FUNERAL DIRECTOR NAME		52. ADDRESS		53. DATE REC'D. BY REGISTRAR			54. REGISTRAR'S SIGNATURE					
Stewart		Funeral Home - 4001 Benning Road, NE		Oct. 8 1984			John Davidson-Hendell					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN HOURS AFTER DEATH. IF ANY DELAY IS NEEDED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 5542			
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Ruth</i>	MIDDLE <i>N</i>	LAST <i>LOCKE</i>	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH 9	DAY 5	YEAR 1984	2b. HOUR M			
3. SEX <i>Female</i>		4 RACE <i>White</i>	5. DATE OF birth MONTH DAY YEAR <i>11-15-04</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>79</i>		IF UNDER 1 YR. MONTHS <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i>	IF UNDER 24 HRS. MIN <i>0</i>	2c. DATE PRONOUNCED DEAD <i>9-5-84</i>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George</i>			
10. CITY OR TOWN OF DEATH <i>Suitland</i>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>5505 Silver Hill Road</i>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Secretary</i>						
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Pr Geo</i>		13c. CITY OR TOWN <i>Suitland</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>5505 Old Silver Hill Road</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Co. Insurance</i>		
14. FATHER'S NAME FIRST <i>Aloysius</i>			MIDDLE <i>C</i>	LAST <i>Thorne</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Annie</i>			MIDDLE <i>V</i>	LAST <i>Phillips</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>577 03 4778</i>			17. INFORMANT ADDRESS <i>John W Locke, Sr. Same as #13</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <i>Diabetes arteriolosclerosis cardiovascular disease</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>			
IMMEDIATE CAUSE <i>Due to, or as a consequence of</i>															
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. <i>(b)</i> Due to, or as a consequence of															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i></i>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>												TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>												ADDRESS <i>5009 Rayburn Ct., Temple Hills, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10 Sept 84			23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN Suitland			COUNTY Maryland	STATE		
24. FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home			25a. DATE REC'D. BY REGISTRAR ADDRESS Suitland Maryland			25b. REGISTRAR'S SIGNATURE <i>Juliann Rodriguez</i>									

A



100000

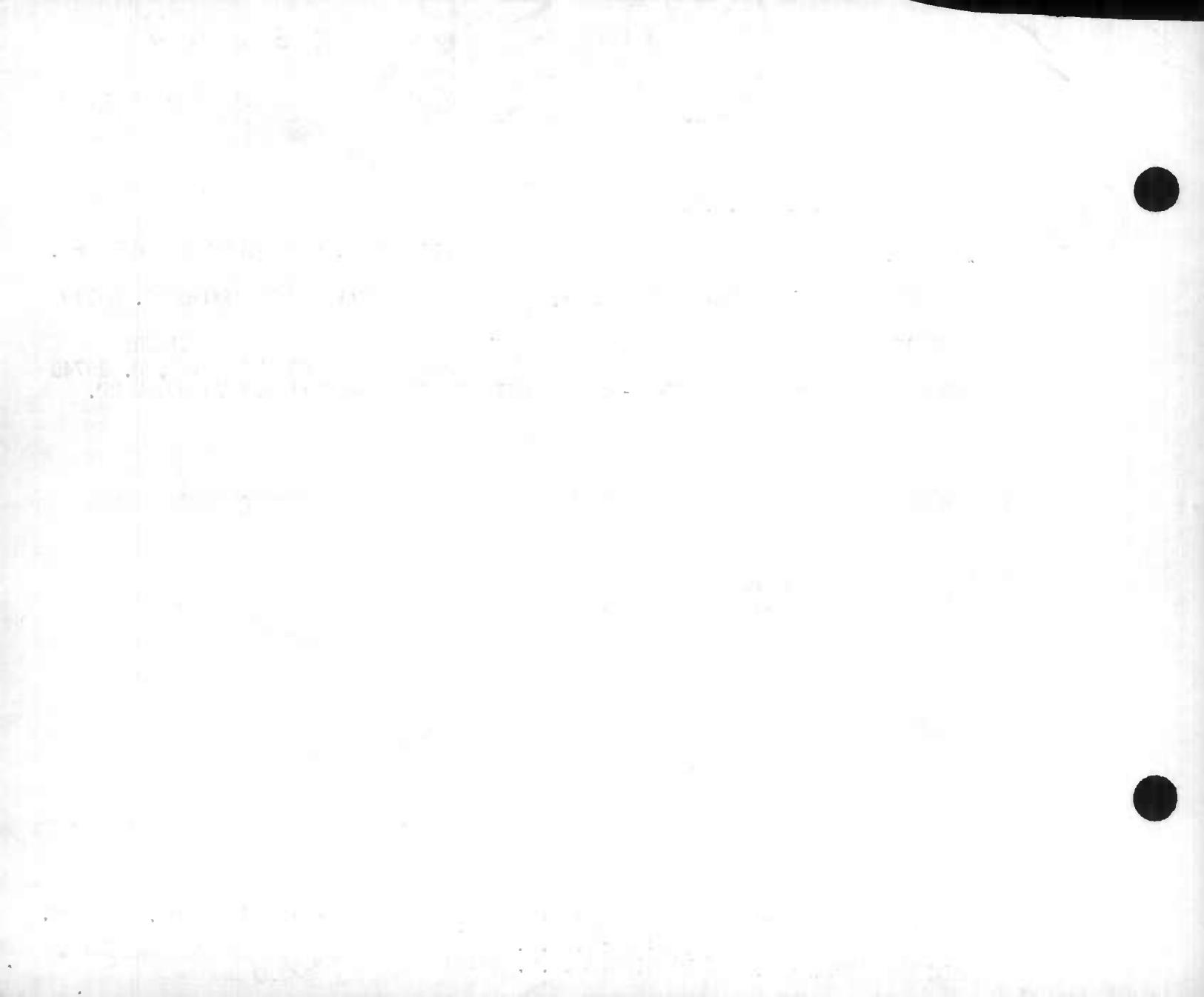
by self please 100 individual 9002  
the specified quantity

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3

retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3  
 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the death certificate  
 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner can be called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25543		
										REG. NO.		
1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b. HOUR		
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		09-08-84			1:05PM		
CARL R. LOEFFLER												
3. SEX			RACE	S. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		
MALE			WHITE	APRIL 6, 1921			63			IF UNDER 24 HRS HOURS MIN.		
YRS.												
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
WASHINGTON, D.C.			U.S.A.						PRINCE GEORGE'S			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
CHEVERLY			PRINCE GEORGE'S GENERAL HOSPITAL			RET. MAIL CARRIER			POST OFC.			
13. STATE			11b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
MARYLAND			PRINCE GEORGES COLLEGE PK.						4711 BERWYN HOUSE RD. 20740			
14. FATHER'S NAME			MIDDLE	14c. MOTHER'S MAIDEN NAME			15. MOTHER'S MAIDEN NAME			MIDDLE		
THOMAS			LOEFFLER				VERA			KINERY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YEAR UNKNOWN) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			16b. SOCIAL SECURITY NO WWII 577-16-6871			17. INFORMANT (WIFE) KATHLEEN LOEFFLER, 4711 BERWYN HOUSE RD.			COLLEGE PARK, MD. 20740			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Recurrent Cancer of Tongue, Seizure</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Dehydration</i>												
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Dehydration</i>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 6, 84</i> , to <i>Sept 8, 84</i> , that (I) (we) last saw the deceased alive on <i>Sept 8, 84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>John J. Biedingolauer MD</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>Sept 8, 84</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BIEDINGOLAUER</i>			22e. ADDRESS <i>6005 Landover Rd</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 9/9/84			23c. NAME OF CEMETERY OR CREMATORIAL CEDAR HILL CREMATORY			23d. LOCATION CITY, TOWN SUITLAND			
									COUNTY PG.	MD.		
24. FUNERAL DIRECTOR NAME RICHARD RAPP, INC.			1804 T ST. N.W. WASHINGTON, D.C. 20009			25a. DATE REC'D. BY REGISTRAR SEP 17 1984			25b. REGISTRAR'S SIGNATURE <i>John J. Biedingolauer</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

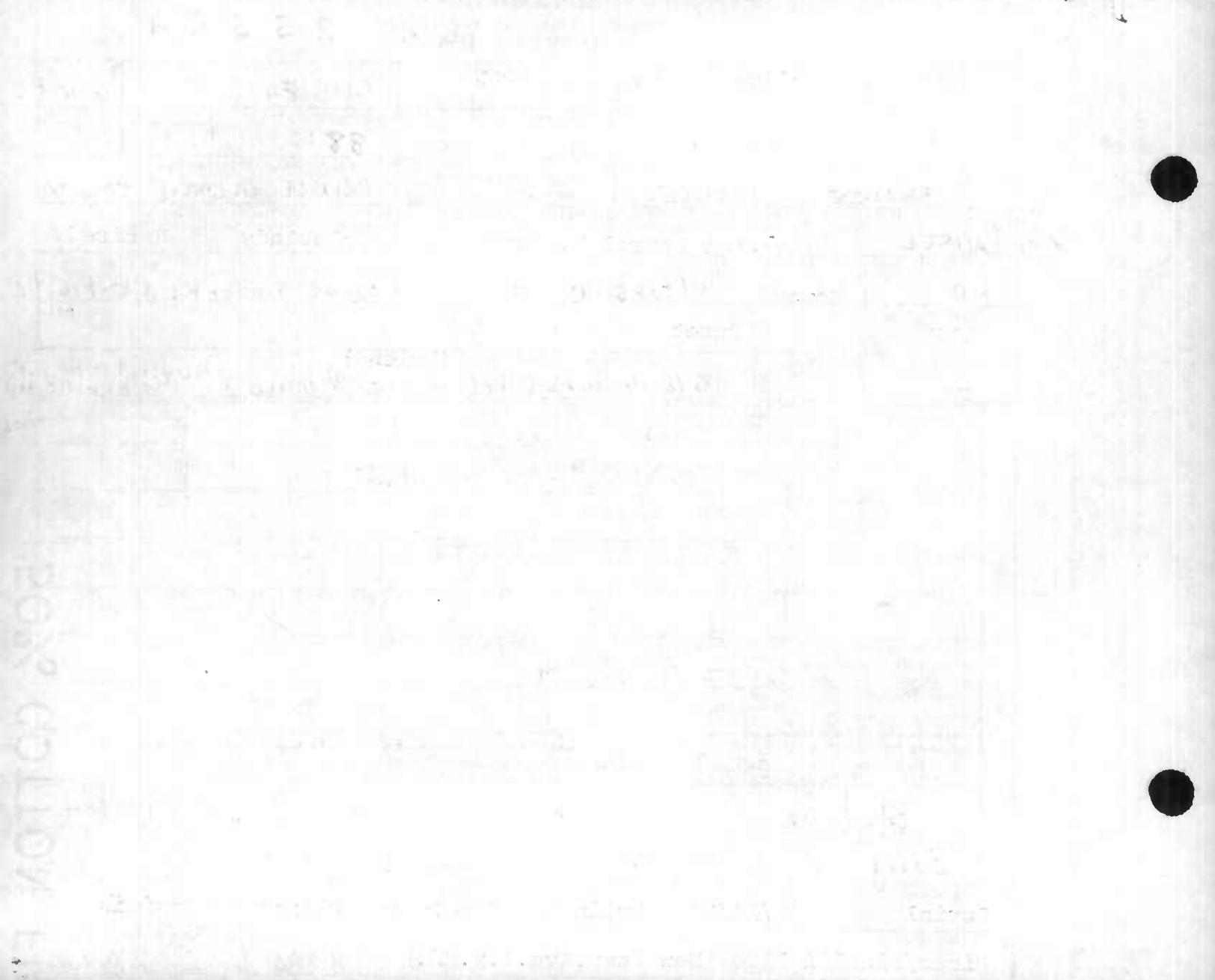
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use at the funeral parlor. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18, show any injury or other traumatic event that caused death.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 25544	
1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Felice</i>	MIDDLE <i>Felice</i>	LAST <i>Long</i>	2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR 6:10 P.M.				
3. SEX <i>F</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH 11 DAY 12 YEAR 1895		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>FRANCE</i>		7b. CITIZEN OF WHAT COUNTRY? <i>FRANCE</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH <i>PRINCE GEORGE COUNTY MD.</i>					
10. CITY OR TOWN OF DEATH <i>LAUREL</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Greater Laurel N. Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Saleslady</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>					
13a. STATE <i>MD</i>		13c. CITY OR TOWN <i>Howard</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS / ZIP CODE <i>5640 Trotter Rd., Clarksville MD 21029</i>					
14. FATHER'S NAME <i>UNK</i>		15. MOTHER'S MAIDEN NAME <i>UNK</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>578-10-3623</i>		17. INFORMANT (Friend) <i>Ethel Marie Demino</i>		ADDRESS <i>5640 Trotter Rd., Clarksville, MD</i>					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebrovascular accident</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>6:10 P.M. 9 11 1984</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) _____							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 19 <i>82</i> , to <i>the present</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>Sept. 10</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>BK Lance</i>		22c. DEGREE <i>M.D.</i>		22d. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN		22e. DATE SIGNED <i>9/11/84</i>					
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Barry K. Lance, M.D.</i>		22g. ADDRESS <i>14201 Laurel Park Dr. Laurel, MD Suite 2223</i>									
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <i>Burial</i>		23b. DATE <i>9/14/84</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Arlington</i> COUNTY <i>Virginia</i> STATE <i>VA</i> 20707					
24. FUNERAL DIRECTOR NAME <i>Hines/Rinaldi</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 13 1984</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pendell</i>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

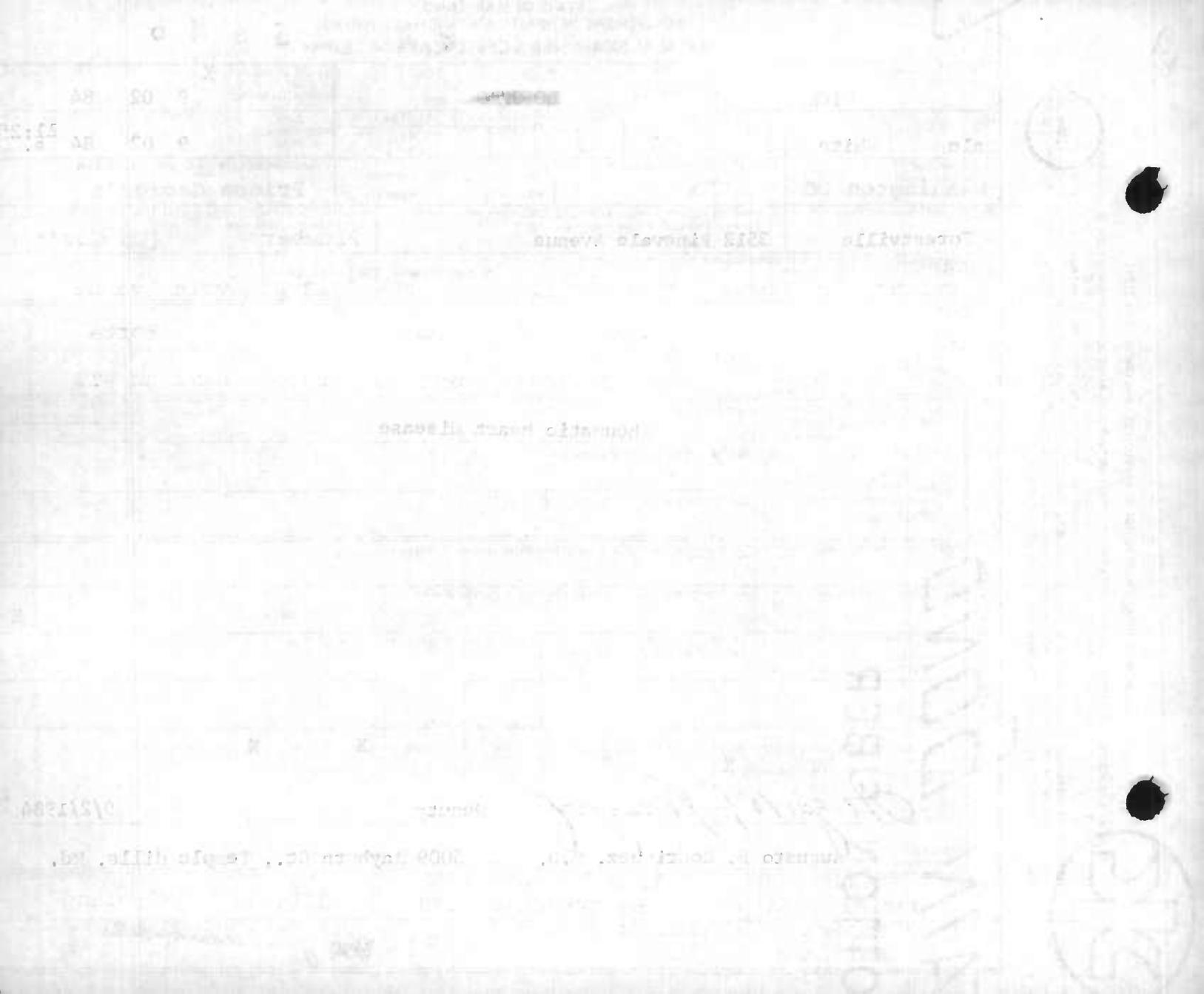
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examination must be done.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												2 5 5 4 5	REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST Caroline	MIDDLE Ellen	LAST Longerbeam	2a. DATE OF DEATH Sept. 27, 1984			MONTH Year	DAY	YEAR	2b. HOUR 1:00 M			
3. SEX Female			4. RACE White		5. DATE OF BIRTH MONTH May 21, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George			MD.					
10. CITY OR TOWN OF DEATH New Carrollton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5813 87th Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home							
13a. STATE Maryland			13b. COUNTY Pr. George		13c. CITY New Carrollton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5813 87th Avenue		20784				
14. FATHER'S NAME FIRST Charles			MIDDLE Fately		15. MOTHER'S MAIDEN NAME FIRST America		MIDDLE V.		LAST Fetzer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. No 579-48-6341		17. INFORMANT Jean Giordano			ADDRESS 5813 87th Ave New Carrollton, Md. 20784							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARPIAC ARREST												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE												6 yrs			
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>7/11/1984</u> to <u>9/19/84</u> , that (I) (we) last saw the deceased alive on <u>7/11/1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 9/28/84			
22b. SIGNATURE <u>Roger B. Ingham</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9/28/84						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROGER B. INGHAM MD</u>			22f. ADDRESS 6510 Tenilleworth Rd. New Carrollton, Md.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 29, 1984			23c. NAME OF CEMETERY OR CREMATORIAL New Haven Memorial Park			23d. LOCATION CITY OR TOWN Glen Burnie, Maryland			24. FUNERAL DIRECTOR NAME Howard Hale's Lanham Fun'l Home 9013 Annapolis Rd., Lanham, Md.		25. DATE REC'D. BY REGISTRAR SFP 2.8 1984	
														26. REGISTRAR'S SIGNATURE <u>Jane Davidson Pendell</u>	

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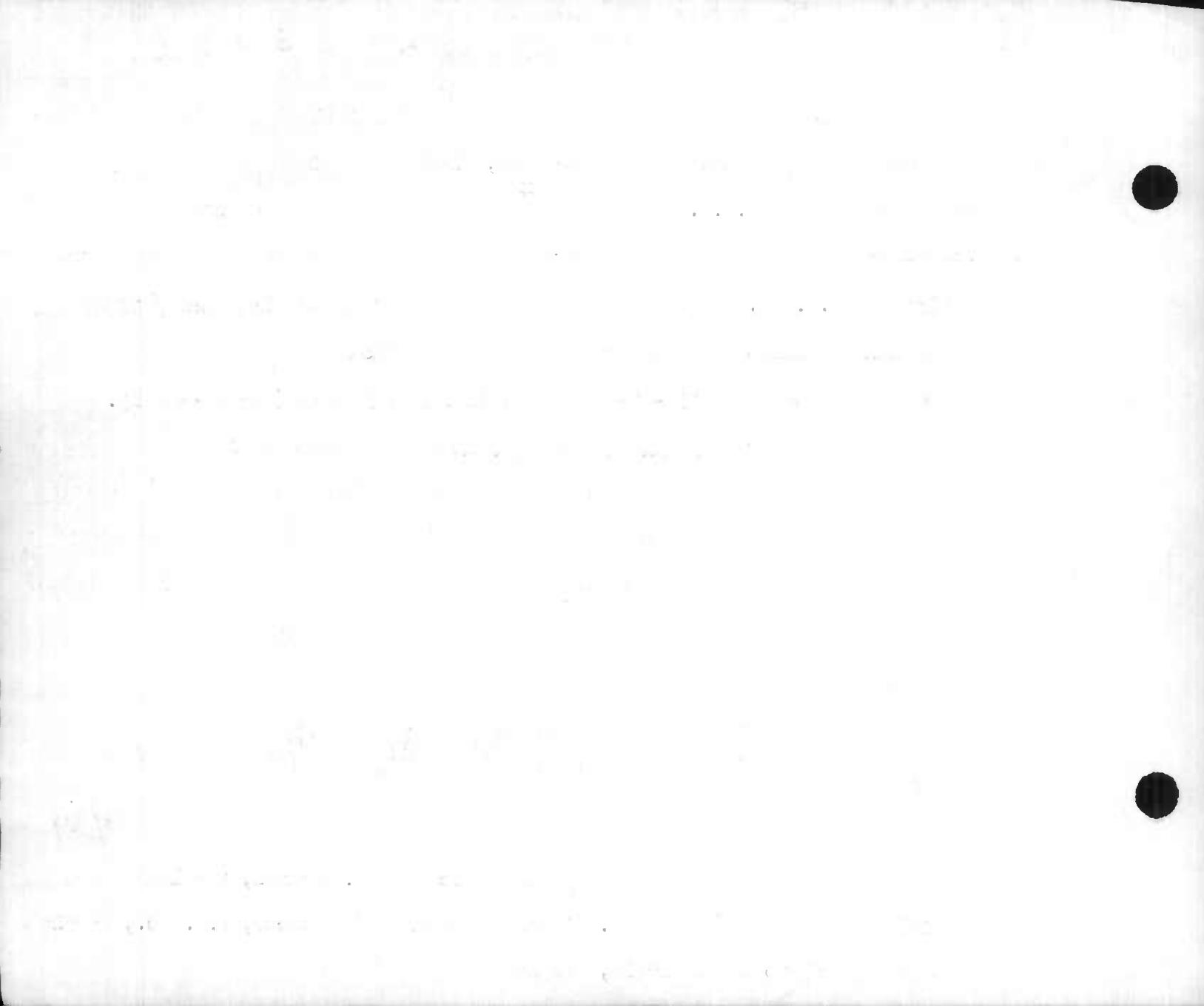


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25541	
												REG. NO.	
1 - FOR STATE REGISTRAR			1. DECEASED NAME			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR	
			FRANCES T. LUMER						SEPT. 14, 1984			2:45PM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR IF UNDER 24 HRS	
Female			White			MONTH DAY YEAR			80 YRS.			MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
North Carolina			U.S.A.						PRINCE GEORGE'S COUNTY				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Laurel			GREATER LAUREL BELTSVILLE HOSPITAL						Waitress			Drug Store	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE				
Maryland		P.G. Co.		Laurel		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			291 Red Clay Road / 20707				
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME							
Daniel			Allen Tedder			Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			None 238-12-0974			Russell Lumer (Husband) Same as # 13.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cardio Respiratory Failure</u>													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Septicemia</u>												1 week	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>and Renal Failure</u>												2 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Congestive Heart Failure, Atherosclerotic Cardiovascular Disease</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER NOTIFY MEDICAL EXAMINER			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>9/14</u> to <u>9/14</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on <u>9/14</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>S. Sadiq</u> DEGREE M.D.												22c. DATE SIGNED <u>9/14/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS							
S. SADIQ						14800 Fourth St. Laurel, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE	
Burial			Sept/18/84			Ft. Lincoln Cemetery			Brentwood, P.G. Co., Maryland				
24. FUNERAL DIRECTOR NAME <u>Chambers Funeral Home</u> ADDRESS <u>Riverdale, Maryland</u>												25. DATE REC'D. BY REGISTRAR <u>SEP 19 1984</u> 25b. REGISTRAR'S SIGNATURE <u>Jeanne Anderson Pendell</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from us or the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25548										
										REG. NO.										
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b. HOUR										
I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST		9 4 84			715am									
ALEJO C.						MACARAEG														
3. SEX			4. RACE			5. DATE OF BIRTH MONTH 6 DAY 8 YEAR 03			6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.								
Male			Filipine			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.											
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8.			10 CITY OR TOWN OF DEATH CLINTON MD			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL			12a USUAL OCCUPATION Retired Fed. Gov't. Machinist			12b KIND OF BUSINESS OR INDUSTRY		
Philippine Islands			USA																	
13a STATE Maryland			13b COUNTY Pr. George			13c CITY OR TOWN Oxon Hill			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE 7307 Roanne Dr. 20745								
14. FATHER'S NAME FIRST Tiburcio			MIDDLE			LAST Macaraeg			15. MOTHER'S MAIDEN NAME FIRST Felipa			MIDDLE			LAST Cabanting					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR OATES) WWII			16c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			17 INFORMANT Lydia C. Macaraeg same as item 13			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 DAYS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						DUE TO, OR AS A CONSEQUENCE OF (b)														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																				
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED							20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 913 19 84			21f. LOCATION STREET 8127 CITY OR TOWN 914 COUNTY 84 STATE														
22a. I certify that (I) <input type="checkbox"/> (his/hospital) attended the deceased from saw the deceased alive on above, (I) <input type="checkbox"/> (did not) view the body after death.										22b. DATE SIGNED 914/84										
22c. SIGNATURE P.W.										22d. DEGREE M.D.										
22e. PHYSICIAN'S NAME (TYPE OR PRINT) P. Wisotsky, M.D.										22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 9/7/84		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood		COUNTY P.G.		STATE Md.		
24. FUNERAL DIRECTOR NAME J.P. Kalas 6160 Oxon Hill Rd.										25a. DATE REC'D. BY REGISTRAR SEP 7 1984		25b. REGISTRAR'S SIGNATURE Jane Davidson-Kendall								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

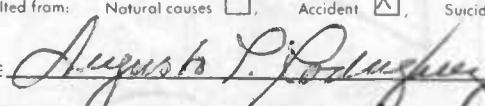
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

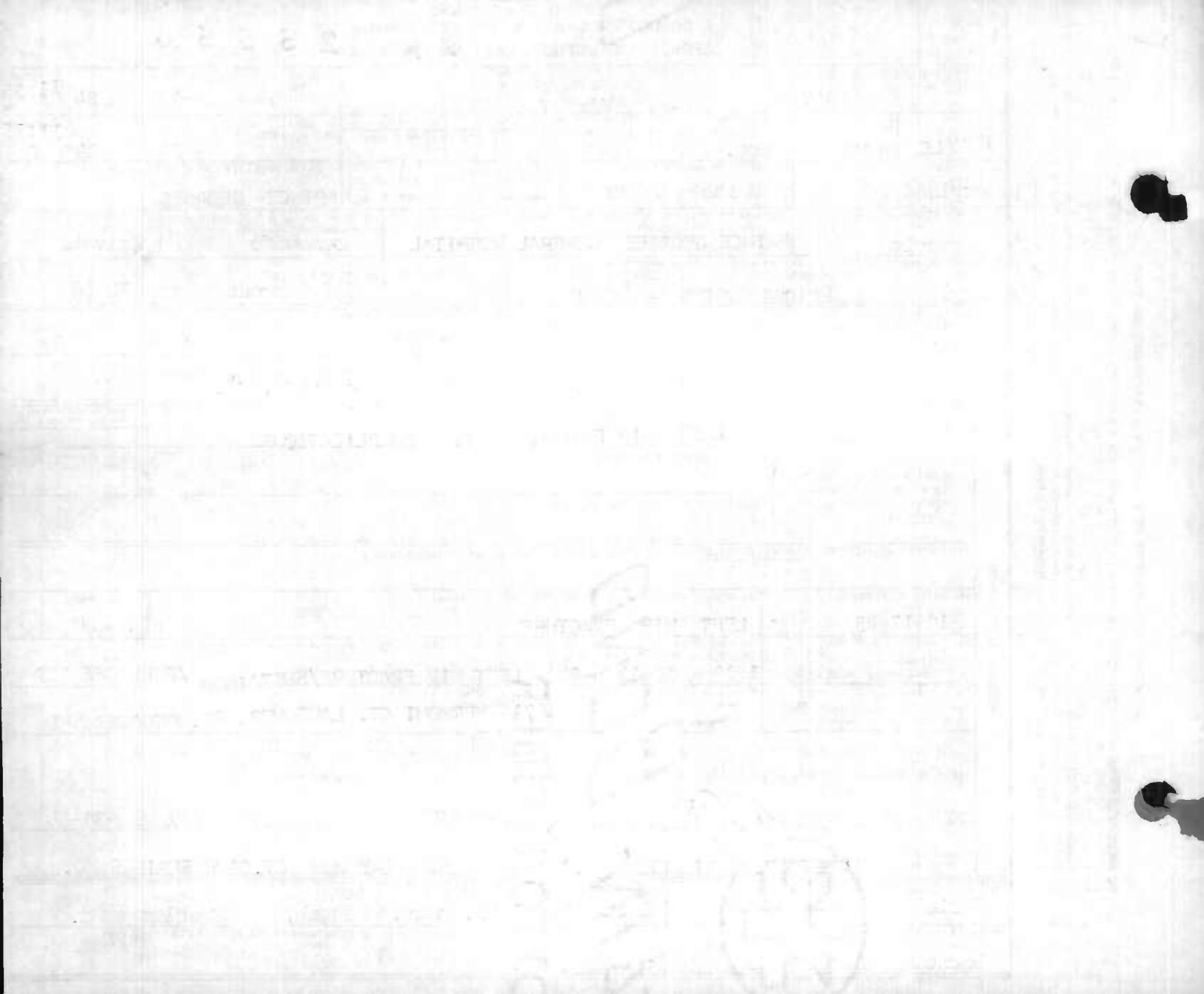
IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25549	
												REG. NO.	
1 - STATE REGISTRAR			1. DECEASED NAME FIRST MIDDLE LAST						2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			MARY P MAGNESS						09 23 84			11 45 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female		White		10 13 05			78 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			PRINCE GEORGE'S COUNTY			
Pennsylvania		U.S.A.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY						
CHEVERLY		PGG HOSPITAL AND MEDICAL CENTER		Administrative			P.G. Hospital						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												Office	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Bladensburg			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 4907 Monroe Street		20710	
14. FATHER'S NAME FIRST Webster		MIDDLE		LAST Marsh			15. MOTHER'S MAIDEN NAME FIRST Mabel			MIDDLE		LAST Purel	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 578 16 2492			17. INFORMANT			ADDRESS Sarah Marsh (Grand Neice) Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST													
DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE CARDIOMYOPATHY													
DUE TO, OR AS A CONSEQUENCE OF (c) RENAL FAILURE													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES MELLITUS HYPERTENSION													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/23/84 19 to 9/23/84 19, that (I) (we) last saw the deceased alive on 9/23/84 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												22c. DATE SIGNED 9/25/84	
22b. SIGNATURE ARVIND M. MEHTA MD		22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARVIND M. MEHTA			22e. ADDRESS 9100 BALTI. AVE. COLLEGE PARK, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/27/84			23c. NAME OF CEMETERY OR CREMATORIALY Arlington National			23d. LOCATION CITY OR TOWN Ft. Myers			COUNTY Maryland		
24 FUNERAL DIRECTOR NAME Francis Gasch's Sons		ADDRESS Hyattsville, Maryland			25a. DATE REC'D. BY REGISTRAR SEP 28 1984			25b. REGISTRAR'S SIGNATURE Julie L. Johnson, R.N.					



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR.  
**PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.**  
**PAGE 4 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS**  
**AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,**  
**BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.**

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 25550	
1- STATE REGISTRAR				FIRST MIDDLE LAST				2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR 9-29 1984				2b. HOUR 11:35 AM	
1. DECEASED NAME (TYPE OR PRINT) <b>MARY H. MARBURY</b>													
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 27, 01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>9-29 1984</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b>		10a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>			
11. CITY OR TOWN OF DEATH <b>Cheverly</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGES GENERAL HOSPITAL</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6715 Vermont Court 20785</b>			
13b. STATE <b>Maryland</b>		13c. COUNTY <b>Prince George Landover</b>		13d. CITY OR TGWN <b>Landover</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mattie Unknown</b>							
14. FATHER'S NAME FIRST <b>Henry</b>		MIDDLE <b>Robinson</b>		16b. SOCIAL SECURITY NO. <b>213-38-2589</b>		17. INFORMANT ADDRESS <b>Mabel Lee 6715 Vermont Court Landover, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>8842</b> IMMEDIATE CAUSE (a) <b>LEFT HIP FRACTURE WITH COMPLICATIONS</b> DUE TO, OR AS A CONSEQUENCE OF { (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION <b>10-17-83</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>LEFT HIP FRACTURE</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>1:00 P.M. 10-14 1984</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>LEFT HIP FRACTURE/SUSTAINED /FELL OFF BED</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>HOME</b>				21f. LOCATION STREET <b>6715 VERMONT CT. LANDOVER, PR. GEORGES, MD.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY) <b>Augusto P. Rodriguez, M.D.</b>	
ACTUAL SIGNATURE  <b>DEPUTY MEDICAL EXAMINER</b>												DATE SIGNED <b>9-30-84</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>AUGUSTO P. RODRIGUEZ, MD.</b>				ADDRESS <b>5009 RAYBURN CT. CAMP SPRINGS, MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-5-84</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Smith Chapel Un. Meth.</b>		23d. LOCATION CITY OR TOWN <b>Pisgah,</b>		23e. COUNTY <b>Charles</b>		STATE <b>Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Thornton Funeral Home</b>				ADDRESS <b>Pomonkey, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 3 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			
BP _____		DHMH - 17 (VR A15 ME (5)) 20M 4/B2											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					2 5 5 5 1								
1 - FOR STATE REGISTRAR						REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
EDWARD G. MARKLEY						SEPTEMBER 12, 1984						08:25PM	
3. SEX			4. RACE	5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male			White	Jan. 1, 1912			MONTH	DAY	YEAR	MONTHS	YEARS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9 BALTIMORE CITY OR COUNTY OF DEATH				
Maryland			U.S.A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			PRINCE GEORGES MD.				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Laurel			GREATER LAUREL BELTSVILLE HOSPITAL			Tour Director			Trailways Bus				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Maryland			P.G. Co.		Laurel		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1011 10th St. 20707			
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	4617				
Albert				Markley	Lora			Belle	Freeland				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No.			213-16-4096			Edith V. Markley			same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Due to, or as a consequence of Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Acute and chronic Respiratory Failure</i> Due to, or as a consequence of (c) <i>Emphysema</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>8/12</i> , 19 <i>84</i> , to <i>9/12</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>9/12</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										22c. DATE SIGNED <i>9-13-84</i>			
22b. SIGNATURE <i>William A. Warner, M.D.</i>										DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>William A. Warner</i>										22e. ADDRESS <i>321 Prince George St Laurel, Md. 20707</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/15/84		23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cem.			23d. LOCATION Brentwood, P.G. Co. Md.					
24. FUNERAL DIRECTOR FLECK FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel, Md. 20707			25a. DATE REC'D. BY REGISTRAR SEP 17 1984			25b. REGISTRAR'S SIGNATURE <i>Jane Davidson-Pendell</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use at the burial-troupe permit. Then please render carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 above any injury, or other traumatic event, the medical examiner shall be notified.

## MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

2 5 5 5 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
FRED - MARKOWITZ							SEPTEMBER 27, 1984				10:30a.m.
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS/LAST BIRTHDAY)				
Male		White		July 14, 1911			73 yrs			IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
7a. BIRTHPLACE COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			7d. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD				
8. CITY OR TOWN OF DEATH Lanham		9. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION DOCTORS' HOSPITAL of P.G. Co.		10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 10a. STATE Maryland			10b. STREET ADDRESS / ZIP CODE 120 Westway Road / 20770			11. KIND OF BUSINESS OR INDUSTRY Meat Cutting	
10c. COUNTY P.G. Co.		10d. CITY OR TOWN Greenbelt		10e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			10f. MOTHER'S MAIDEN NAME Lena (Unknown)				
11. FATHER'S NAME Samuel		MIDDLE	LAST	12. SOCIAL SECURITY NO. WWII			13. INFORMANT Anna M. Markowitz (Wife) Same as #13.			14. ADDRESS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16. IMMEDIATE CAUSE (a) molar tooth hyperplasia		17. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
18. CAUSE OF DEATH (Enter only one cause per line for 10, 11, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		19. DUE TO, OR AS A CONSEQUENCE OF (b)		20. DUE TO, OR AS A CONSEQUENCE OF (c)							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		21c. AUTOPSY?			21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21e. NATURE OF INJURY (IN ITEM 21, PART I, OR PART 2)	
21f. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21g. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21h. HOW INJURY OCCURRED							
21i. INJURY OCCURRED		21j. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21l. LOCATION STREET			21m. CITY OR TOWN			21n. COUNTY	
21o. I certify that (I) (the hospital) attended the deceased from saw the deceased alive on 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.		21p. DECEASED		21q. ATTENDING PHYSICIAN NAME <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			21r. DATE SIGNED 19/27/84			21s. DATE SIGNED 19/27/84	
22a. PHYSICIAN'S NAME (TYPE OR PRINT)		22b. ADDRESS		22c. DECEASED			22d. ADDRESS			22e. DATE SIGNED 20903	
Lewis H. Dennis MD		831 University Blvd, Silver Spring, MD									
23a. BURIAL, CREMATION, REMOVAL (TYPE)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTY	
Burial		Oct/1/84		Cedar Hill Cemetery			Suitland, P.G. Co., Maryland			STATE	
24. FUNERAL DIRECTOR NAME Chambers Funeral Home		ADDRESS Riverdale, Maryland		25a. DATE REC'D. BY REGISTRAR Oct 3 1984			25b. REGISTRAR'S SIGNATURE John Davidson-Kendall				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR IN PENCIL IN ITEM 18. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FOR A FM 3 RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 25553

1. DECEASED NAME (TYPE OR PRINT)			FIRST Isaac	MIDDLE S.	LAST Marshall	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH 9-15 1984	DAY YEAR	2b. HOUR M 3:51 a.m.
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Feb. 9, 1930	6. AGE (IN YEARS LAST BIRTHDAY) 54 yrs.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 9-15 1984	MONTH DAY YEAR	2d. HOUR 3:51 a.m.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.		
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver		12b. KIND OF BUSINESS OR INDUSTRY Driving	
13a. STATE D.C.	13b. COUNTY N/A	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 245 58th St., N.E.	999449		
14. FATHER'S NAME FIRST William		MIDDLE E.	LAST Marshall	15. MOTHER'S MAIDEN NAME FIRST Irene		LAST Deal		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-36-7241		17. INFORMANT Michael Marshall-1014 Galloway St. N.		ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Dennis F. Smyth, M.D.		TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER						
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St., Balto., Md. 21201						
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 9/20/84	23c. NAME OF CEMETERY OR CREMATORIAL HARMONY ATOM. PARK		23d. LOCATION CITY OR TOWN HIGHLAND PARK, P.G., MD.		COUNTY STATE	
24. FUNERAL DIRECTOR NAME H. S. WASHINGTON & SONS		ADDRESS 1925 Burroughs Avenue	25a. DATE REC'D. BY REGISTRAR CFP 20 1984		25b. REGISTRAR'S SIGNATURE Julia L. Dearden, R.R.			
25. DMH - 17 (VR A15 ME (5)) 20M 4/82								

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A

